

**UNITEDHEALTHCARE INSURANCE COMPANY**  
**ENROLLMENT FORM FOR PART-TIME STUDENTS AND ALL DEPENDENTS**  
**OHIO NORTHERN UNIVERSITY**

PROCESSOR STAMP DATE RECEIVED HERE

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**2013-1097-1**

<b>PRIMARY INSURED</b> Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
<b>LAST (FAMILY) NAME:</b>		<b>FIRST (GIVEN) NAME:</b>	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH YEAR	
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

**DEPENDENT INFORMATION:** Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

<b>SPOUSE SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:

**NOTICE TO STUDENT:** Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

**NOTICE:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

CAMPUS/SCHOOL ATTENDING: Ohio Northern University

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

**PLEASE CHECK ALL APPROPRIATE BOXES**

**INSURED CATEGORY:**  Part-Time  Full-Time / International  Visiting Scholar

<b>PERIOD CODES</b>	<b>Annual (A-)</b>	<b>Fall (F-)</b>	<b>Spring / Summer (J-)</b>	<b>Summer (S-)</b>
<b>ID CODES</b>				
1 Student	<input type="checkbox"/> \$ 1,299.00	<input type="checkbox"/> \$ 565.00	<input type="checkbox"/> \$ 685.00	<input type="checkbox"/> \$ 223.00
2 Spouse	<input type="checkbox"/> \$ 2,292.00	<input type="checkbox"/> \$ 1,057.00	<input type="checkbox"/> \$ 1,281.00	<input type="checkbox"/> \$ 416.00
3 Each Child	<input type="checkbox"/> \$ 1,624.00	<input type="checkbox"/> \$ 749.00	<input type="checkbox"/> \$ 908.00	<input type="checkbox"/> \$ 295.00

**PLEASE CHECK ALL APPROPRIATE BOXES**

**EFFECTIVE / EXPIRATION PERIODS:**

- Annual  08-01-2013 to 07-31-2014  
 Fall  08-01-2013 to 01-12-2014  
 Spring / Summer  01-13-2013 to 07-31-2014  
 Summer  05-28-2012 to 07-31-2014

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment card along with premium payment to:  
 UnitedHealthcare **StudentResources**  
 PO Box 809026  
 Dallas, TX 75380-9026.

Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

**Dependents only:** To request dependent coverage and pay online using a credit card or eCheck, please go to [www.uhcsr.com/control](http://www.uhcsr.com/control) and select the "Do you Need a Control Number?" link on the home page. Follow the on screen prompts to request coverage for your dependent. Make sure your email address is correct; we will enter your coverage request into our system and send you an email with instructions for making your premium payment online with a credit card or eCheck.