

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
University of Illinois - Urbana/Champaign

PROCESSOR STAMP DATE RECEIVED HERE

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2013-1351-2

PRIMARY INSURED Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	EXPECTED DATE OF GRADUATION: _____/_____/_____	
	MONTH	DAY	YEAR
	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).

SPOUSE SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH: _____/_____/_____	
				MONTH DAY YEAR	
First (Given) Name		Middle Initial:	Last (Family) Name:		
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH: _____/_____/_____	
				MONTH DAY YEAR	
First (Given) Name		Middle Initial:	Last (Family) Name:		
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH: _____/_____/_____	
				MONTH DAY YEAR	
First (Given) Name		Middle Initial:	Last (Family) Name:		
CHILD SOCIAL SECURITY #:		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		DATE OF BIRTH: _____/_____/_____	
				MONTH DAY YEAR	
First (Given) Name		Middle Initial:	Last (Family) Name:		
CHILD SOCIAL SECURITY #:		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 knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

STUDENT'S SIGNATURE: _____

DATE: _____

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: Any applicable category

PERIOD CODES	Annual (A-)	Fall (F-)	Spring (G-)	Spring/ Summer (J-)	Summer (S-)
ID CODES					
2 Spouse	<input type="checkbox"/> \$ 3,823.00	<input type="checkbox"/> \$ 1,274.00	<input type="checkbox"/> \$ 1,274.00	<input type="checkbox"/> \$ 2,548.00	<input type="checkbox"/> \$ 1,274.00
3 All Children	<input type="checkbox"/> \$ 1,910.00	<input type="checkbox"/> \$ 637.00	<input type="checkbox"/> \$ 637.00	<input type="checkbox"/> \$ 1,274.00	<input type="checkbox"/> \$ 637.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-21-2013 to 08-20-2014
Fall	<input type="checkbox"/> 08-21-2013 to 01-17-2014
Spring	<input type="checkbox"/> 01-18-2013 to 05-16-2014
Spring / Summer	<input type="checkbox"/> 01-18-2014 to 08-20-2014
Summer	<input type="checkbox"/> 05-17-2014 to 08-20-2014

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.