Processor Stamp Date Received Here

UNITEDHEALTHCARE INSURANCE COMPANY

CONTINUATION ELECTION FORM FOR DOMESTIC STUDENTS AND THEIR DEPENDENTS

BEMIDJI STATE UNIVERSITY

2013-1530-1

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:		OR STUDENT ID #:
LAST (FAMILY) NAME:	**FIRST (GIVEN) NAME:**	MIDDLE INITIAL:
GENDER: ❑ MALE ❑ 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).

SPOUSE SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _______/ _______/ __________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _______/ _______/ __________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _______/ _______/ __________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _______/ _______/ __________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _______/ _______/ __________ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:

NOTICE TO STUDENT: Coverage is effective immediately following the expiration of the regularstudent plan and must be purchased within 14 days after the expiration date of your student coverage. If premium is not received within 14 days, the premium will be refunded. 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. A student who requests to cancel coverage under the Policy will receive a refund of unearned premiums as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the insured within 30 days following the receipt of the insured's request for cancellation.

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: ____________________

BEMIDJI STATE UNIVERSITY

2013-1530-1

CAMPUS LOCATION: BEMIDJI STATE UNIVERSITY

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

Eligibility: All Insured Persons who have been continuously insured under the school's regular student policy for at least 4 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ **Continuation**

PERIOD CODES		Monthly (MX) (90 days maximum)
ID CODES		
4	Continuing Student	❑ $ 410.00
5	Spouse	❑ $1 ,323.00
6	Each Child	❑ $ 606.00

.

Periods:

Monthly	❑ 08-26-2013 to 09-25-2013	❑ 09-26-2013 to 10-25-2013
	❑ 10-26-2013 to 11-25-2013	❑ 11-26-2013 to 12-25-2013
	❑ 12-26-2013 to 01-25-2014	❑ 01-26-2014 to 02-25-2014
	❑ 02-26-2014 to 03-25-2014	❑ 03-26-2014 to 04-25-2014
	❑ 04-26-2014 to 05-25-2014	❑ 05-26-2014 to 06-25-2014
	❑ 06-26-2014 to 07-25-2014	❑ 07-26-2014 to 08-25-2014

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due
Example: $410.00 x 3 months = $1,230.00
(90 days maximum)

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $________________
Multiply by # of months: ________________
Total premium enclosed: $________________

PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 90 days, but not longer than the current plan year. Incorrect payment amounts will be returned and no coverage will be in effect.

If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (90 days of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:

UnitedHealthcare **Student**Resources
PO Box 809026
Dallas, TX 75380-9026

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