PROCESSOR STAMP DATE RECEIVED HERE

FRONTIERMEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE
ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION
FOR STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF SOUTHERN MISSISSIPPI

2013-1700-1

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:	
HOME COUNTRY:	HOST COUNTRY:	
REQUESTED PROGRAM START DATE:	HOST INSTITUTION/CENTER NAME:	
HOST INSTITUTION/CENTER ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE #:

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:

STUDENT'S SIGNATURE: ____ DATE: ___________________________

CAMPUS/SCHOOL ATTENDING: _____

Please Print Name of University. Must be completed in order for application to be processed.

NOTE: Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations. All Global Emergency Services must be arranged and provided by FrontierMEDEX, any services not arranged by FrontierMEDEX will not be considered for payment.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ Standalone Repatriation/Medical Evacuation

PERIOD CODES Annual (A-)

ID CODES

7.	Student	❑ $	75.00
8.	Spouse	❑ $	75.00
9.	Each Child	❑ $	75.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual ❑ 08-15-2013 to 08-14-2014

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: $75.00 x 3 months = $225.00

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

Holland Insurance Inc.
PO Box 328
Southhaven, MS 38671.

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.