

UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ELECTION FORM FOR DOMESTIC STUDENTS
AND THEIR DEPENDENTS

2013-1751-1

MINNESOTA STATE UNIVERSITIES

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: _____ / _____ / _____ 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: <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 is effective immediately following the expiration of the student 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: _____

CAMPUS LOCATION:

- Metropolitan State University Policy # 2013-1768-1
- Minnesota State University-Mankato Policy # 2013-1769-1
- St. Cloud State University Policy # 2013-1666-1
- Southwest Minnesota State University Policy # 2013-1675-1
- Winona State University Policy # 2013-1682-1

I elect to purchase Injury and Sickness insurance coverage under the College'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.

<p>PLEASE CHECK ALL APPROPRIATE BOXES</p> <p>INSURED CATEGORY: <input type="checkbox"/> Continuation</p> <p style="text-align: right;">Monthly (MX) (90 days maximum)</p> <p>PERIOD CODES</p> <p>ID CODES</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 20px;">5</td> <td style="width: 150px;">Continuing Student</td> <td style="width: 50px;"><input type="checkbox"/> \$ 538.00</td> </tr> <tr> <td>6</td> <td>Spouse</td> <td><input type="checkbox"/> \$ 1,737.00</td> </tr> <tr> <td>7</td> <td>Each Child</td> <td><input type="checkbox"/> \$ 794.00</td> </tr> </table>	5	Continuing Student	<input type="checkbox"/> \$ 538.00	6	Spouse	<input type="checkbox"/> \$ 1,737.00	7	Each Child	<input type="checkbox"/> \$ 794.00	<p>Periods:</p> <p>Monthly <input type="checkbox"/> 08-26-2013 to 09-25-2013 <input type="checkbox"/> 09-26-2013 to 10-25-2013</p> <p><input type="checkbox"/> 10-26-2013 to 11-25-2013 <input type="checkbox"/> 11-26-2013 to 12-25-2013</p> <p><input type="checkbox"/> 12-26-2013 to 01-25-2014 <input type="checkbox"/> 01-26-2014 to 02-25-2014</p> <p><input type="checkbox"/> 02-26-2014 to 03-25-2014 <input type="checkbox"/> 03-26-2014 to 04-25-2014</p> <p><input type="checkbox"/> 04-26-2014 to 05-25-2014 <input type="checkbox"/> 05-26-2014 to 06-25-2014</p> <p><input type="checkbox"/> 06-26-2014 to 07-25-2014 <input type="checkbox"/> 07-26-2014 to 08-25-2014</p>
5	Continuing Student	<input type="checkbox"/> \$ 538.00								
6	Spouse	<input type="checkbox"/> \$ 1,737.00								
7	Each Child	<input type="checkbox"/> \$ 794.00								

<p>TO CALCULATE YOUR RATE:</p> <p>Rate x # of months eligible = amount due</p> <p>Example: \$538.00 x 3 months = \$1,614.00</p> <p>(3 month maximum)</p>	<p>CALCULATION FOR MONTHLY PREMIUM:</p> <p>Monthly premium: \$ _____</p> <p>Multiply by # of months: _____</p> <p>Total premium enclosed: \$ _____</p>
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EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Annual 08-26-2013 to 08-25-2014

PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 3 consecutive months, 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 (3 Months 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. Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 14 days after the expiration date of your previous continuation coverage. If premium is not received within 14 days, the premium will be refunded.

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