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UNITEDHEALTHCARE INSURANCE COMPANY
ELECTION FORM FOR DEPENDENTS OF INTERNATIONAL STUDENTS

MINNESOTA STATE UNIVERSITIES

2013-1757-4

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 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. 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. Insurance coverage is required as a condition of enrollment in a Minnesota State College and University (MnSCU) institution. Your request for cancellation will be verified with the MnSCU student office as to your enrollment status.

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: ____________________

MINNESOTA STATE UNIVERSITIES 2013-1757-4

INTERNATIONAL, F-VISA AND J-VISA SCHOLAR STUDENTS MUST CONTACT THEIR SCHOOL'S INTERNATIONAL OFFICE OR STUDENT HEALTH CENTER TO ENROLL IN THIS INSURANCE. DEPENDENTS OF ENROLLED STUDENTS MAY PURCHASE THIS INSURANCE BY FOLLOWING THE PAYMENT INSTRUCTIONS OR DEPENDENT ENROLLMENT INSTRUCTIONS AT THE BOTTOM OF THIS FORM.

CAMPUS LOCATION:

❑ Bemidji State University Policy # 2013-1530-4

❑ Minnesota State University-Mankato Policy # 2013-1769-4

❑ Minnesota State University-Moorhead# 2013-1661-4

❑ St. Cloud State University Policy # 2013-1666-4

❑ Southwest Minnesota State University Policy # 2013-1675-4

❑ Winona State University Policy # 2013-1682-4

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ International

PERIOD CODES / ID CODES		Annual (A-)	Fall (F-)	Fall/Spring (H-)	Spring/Summer (J-)	Summer (S-)
2	Spouse	❑ $ 3,338.00	❑ $1,271.00	❑ $ 2,497.00	❑ $ 2,067.00	❑ $ 969.00
3	Each Child	❑ $ 2,070.00	❑ $ 788.00	❑ $ 1,548.00	❑ $ 1,282.00	❑ $ 601.00

EFFECTIVE AND TERMINATION DATES:

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

Annual	❑ 08-15-2013 to 08-14-2014
Fall	❑ 08-15-2013 to 12-31-2013
Fall/Spring	❑ 08-15-2013 to 05-14-2014
Spring/Summer	❑ 01-01-2014 to 08-14-2014
Summer	❑ 05-01-2014 to 08-14-2014

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 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 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.