PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY
ELECTION FORM FOR INTERNATIONAL STUDENTS AND THEIR DEPENDENTS

METROPOLITAN STATE UNIVERSITY

2013-1768-4

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.

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 2013-1768-4

❑ **I elect to purchase blanket Injury and Sickness insurance coverage under the College's student blanket 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-)**
1	Student	❑ $ 1,162.00	❑ $ 442.00	❑ $ 869.00	❑ $ 720.00	❑ $ 338.00
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.