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UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR DEPENDENTS

Eastern Virginia Medical School

2013-193-1

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 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. Premium will not be refunded except for ineligibility or entrance into the armed forces.

NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

STUDENT'S SIGNATURE: ______________________________ DATE: ____________________

Eastern Virginia Medical School 2013-193-1

CAMPUS LOCATION:

CAMPUS/SCHOOL ATTENDING: Eastern Virginia Medical School

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ **1st Year Surgical Assistants** ❑ **Masters of Public Health (Medical-MD)** ❑ **Physician Assistants** ❑ **Physician Assistant 3rd Year**

PERIOD CODES		Annual (A-)	Fall (F-)	Spring (G-)
ID CODES				
2	One Dependent	❑ $ 3,599.00	❑ $ 1,799.50	❑ $ 1,799.50
3	All Dependents	❑ $10,689.00	❑ $ 5,344.50	❑ $ 5,344.50

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction, of your school.

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-01-2013 to 07-31-2014
Fall	❑ 08-01-2013 to 01-02-2014
Spring	❑ 01-03-2014 to 07-31-2014

EFFECTIVE AND TERMINATION DATES:

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

Annual coverage expires 1 year following receipt of your premium or July 31, 2014, whichever is earlier.

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.