PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR GTA/GRA/GA AND THEIR DEPENDENTS

KANSAS BOARD OF REGENTS STATE UNIVERSITIES

2013-200118-3

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: If this enrollment form and appropriate premium are received by UHCSR within the 60 days outlined in the above Eligibility Requirement section, Continuation Insurance will be effective on the first day following termination of previous coverage. Subsequent premiums are due at UHCSR on the first day of each month for which insurance is being purchased. UHCSR will NOT issue premium reminder notices. It is the student's responsibility to make timely renewal payments. All premiums should be submitted to the address in the Payment Instructions box above. By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described above: 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Premium will not be refunded except for ineligibility or entrance into the armed forces.
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: ____________________

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CAMPUS LOCATION:

CAMPUS/SCHOOL ATTENDING: _____

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

❑ Emporia State University	2013-197-3	❑ Kansas State University	2013-470-3
❑ Wichita State University	2013-180-3	❑ University of Kansas Medical Center	2013-2070-3
❑ University of Kansas	2013-471-3	❑ Pittsburg State University	2013-2009-3

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

ELIGIBILITY REQUIREMENT: Insureds may pay for continuing coverage for a maximum of up to 3 months due to loss of appointment. The Insured has a right to choose to continue benefits as long as the school maintains a plan with our Company. The Insured must exercise this right within 60 days of termination by calling UnitedHealthcare **Student**Resources at 1-888-344-6104 or see the designated contact for your university. Upon request a Certificate of prior creditable coverage will be provided when an employee or their dependent ceases to be covered under this policy.

The Insured must exercise this right within 60 days of termination. Application and full premium must be received within 60 days after your expiration date under the student plan from which continuation is allowed. If you do not enroll within 60 days, you are no longer eligible for coverage.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ Continuation

PERIOD CODES / ID CODES		Monthly (MX)
7	Student	❑ $ 112.00
8	Spouse	❑ $ 452.00
9	All Children	❑ $ 389.00

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: $115.00 x 3 months = $345.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: **$**_____

Multiply by # of months: _____

Total premium enclosed: **$**_____

PAYMENT INSTRUCTIONS:

CHECK OR MONEY ORDER: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this completed 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.