

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
DEVRY COLLEGE OF NEW YORK

PROCESSOR STAMP DATE RECEIVED HERE

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2013-278-6

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

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

STUDENT'S SIGNATURE: _____ DATE: _____

CAMPUS/SCHOOL ATTENDING: _____

Please Print Name of DeVry College of New York. Must be completed in order for application to be processed.

I elect to purchase Injury and Sickness insurance coverage under the University'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 9 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 ninety 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.

PLEASE CHECK ALL APPROPRIATE BOXES
INSURED CATEGORY: Continuation

PERIOD CODE	Monthly (MX) (90 Day Maximum)		
Under Age 30:		Age 30 to 39:	
ID CODES		ID CODES	
13 Student	<input type="checkbox"/> \$ 93.00	14 Student	<input type="checkbox"/> \$ 115.00
17 Spouse	<input type="checkbox"/> \$ 323.00	17 Spouse	<input type="checkbox"/> \$ 323.00
18 All Children	<input type="checkbox"/> \$ 226.00	18 All Children	<input type="checkbox"/> \$ 226.00
Age 40 to 49:		Age 50 and Older:	
ID CODES		ID CODES	
15 Student	<input type="checkbox"/> \$ 169.00	16 Student	<input type="checkbox"/> \$ 249.00
17 Spouse	<input type="checkbox"/> \$ 323.00	17 Spouse	<input type="checkbox"/> \$ 323.00
18 All Children	<input type="checkbox"/> \$ 226.00	18 All Children	<input type="checkbox"/> \$ 226.00

Note: The amounts stated above include certain fees, which include amounts that are paid to certain non-insurer vendors or consultants by, or at the direction of your school.

EFFECTIVE / EXPIRATION PERIODS:

Continuation Monthly

TO CALCULATE YOUR RATE:
 Rate x # of months eligible = amount due
 Example: \$93.00 x 3 months = \$279.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____

Multiply by # of months: _____

Total premium enclosed: \$ _____

***PLEASE NOTE:** The Continuation Privilege will allow you to purchase up to a maximum of 90 days, 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 (90 days 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 10 days after the expiration date of your previous continuation coverage. If premium is not received within 10 days, the premium will be refunded.

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** name of authorized representative 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.

To enroll online: If you would like to enroll online, please go to www.uhcsr.com/DeVry and select the Enroll Now link to enroll online.