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UNITEDHEALTHCARE INSURANCE COMPANY

CONTINUATION ENROLLMENT FORM FOR BASIC STUDENTS AND THEIR DEPENDENTS

2013-451-1

UNIVERSITY OF CHICAGO

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 is effective immediately following the expiration of the regularstudent plan and must be purchased within 31 days after the expiration date of your student coverage. If premium is not received within 31 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 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: ______________________

UNIVERSITY OF CHICAGO 2013-451-1

CAMPUS/SCHOOL ATTENDING: **UNIVERSITY OF CHICAGO**

Please Print Name of University 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 6 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 6 months 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**

		Monthly (MX)
PERIOD CODES		
ID CODES		
11	Student	❑ $ 363.00
12	Spouse	❑ $ 636.00
13	All Children	❑ $ 636.00
14	All Dependents	❑ $ 1,181.00

EFFECTIVE / EXPIRATION PERIODS:

Annual 09-01-2013 to 08-31-2014

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. **Requested Effective Date:** ____/____/____

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due

Example: $363.00 x 3 months = $1,089.00

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 6 consecutive months, 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 (6 Months 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 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded.

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 is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.