PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR EARLY ARRIVING STUDENTS AND THEIR DEPENDENTS

BASIC PLAN EARLY ARRIVING

UNIVERSITY OF CHICAGO

2013-451-1

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: 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/SCHOOL ATTENDING: UNIVERSITY OF CHICAGO

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:

1ST YEAR MEDICAL STUDENTS

PERIOD CODES **1st Special (E1)**

ID CODES

1	Student	❑ $ 252.00
2	Spouse	❑ $ 432.00
3	Each Child	❑ $ 432.00
4	All Dependents	❑ $ 802.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE / EXPIRATION PERIODS:

1st Special ❑ 08-01-2013 to 08-31-2013

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:

ATHLETES & INTENSIVE ENGLISH STUDENTS (or new students required by their academic program to arrive on campus early)

PERIOD CODES **2nd Special (E2)**

ID CODES

1	Student	❑ $ 163.00
2	Spouse	❑ $ 279.00
3	Each Child	❑ $ 279.00
4	All Dependents	❑ $ 517.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE / EXPIRATION PERIODS:

2nd Special ❑ 08-12-2013 to 08-31-2013

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.