PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY

CONTINUATION ENROLLMENT FORM FOR STUDENTS

UNIVERSITY OF WYOMING

2013-5857-1

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 [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:		

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.

STUDENT'S SIGNATURE: _____ DATE: _____

UNIVERSITY OF WYOMING 2013-5857-1

ELIGIBILITY: All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 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 90 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.

CAMPUS/SCHOOL ATTENDING: _____**UNIVERSITY OF WYOMING**_____

❑ **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: ❑ **Continuation**

PERIOD CODES	**Monthly (MX) (90 day maximum)**
ID CODES	
2 Student	❑ $ 158.00

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due

Example: $158.00 x 3 months = $474.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: **$**_____

Multiply by # of months: _____

Total premium enclosed: **$**_____

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.