UNITEDHEALTHCARE INSURANCE COMPANY CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

AMERICAN UNIVERSITY

2014-101-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.							
SOCIAL SECURITY #:		OR STUDENT ID #:					
LAST (FAMILY) NAME:	FIRST (GIVEN) NAI	ΛE:			MIDDLE INITIAL:		
GENDER: DATE OF BIRTH: MALE FEMALE (MONTH/DAY/YEAR)			EXPECTI (MONTH/		D DATE OF GRADUATION: EAR)		
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)							
CITY:		STATE:		ZIP	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 GENDER:							
SECURITY #:				NTH/DAY/YEAR)			
First (Given) Name:	Middle Initial:			nily) Name:			
CHILD SOCIAL SECURITY #:	GENDER:			TE OF BIRTH: DNTH/DAY/YEAR)			
First (Given) Name:	Middle Initial:		Last (Far	nily) Name:			
CHILD SOCIAL SECURITY #:	GENDER:			E OF BIRTH: NTH/DAY/YE	AR)		
First (Given) Name:	Middle Initial:		Last (Far	nily) Name:			
CHILD SOCIAL SECURITY #:	GENDER:			E OF BIRTH: NTH/DAY/YE	AR)		
First (Given) Name:	Middle Initial:		Last (Far	nily) Name:			
CHILD SOCIAL SECURITY #:	GENDER:			E OF BIRTH: NTH/DAY/YE	AR)		
First (Given) Name:	Middle Initial:		Last (Far	nily) Name:			

NOTICE TO STUDENT: Coverage will be effective immediately following the expiration of the regularstudentplan 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 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 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.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Date: _____

Campus/School Attending:

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.

INS	SURED CATEGORY:		Continuation		
Period Codes		Monthly (MX) (6 months maximum)			
ID C	Codes				
23	Student	□\$	258.00		
24	Spouse	□\$	937.00		
25	Each Child	□\$	566.00		
26	All Children	□\$	986.00		
27	All Dependents	□\$	1,923.00		

EFFECTIVE/EXPIRATION PERIODS:

Annual 8/1/2014 to 7/31/2015

TO CALCULATE YOUR RATE:Rate x # of months eligible = amount dueExample: \$258.00 x 6 months = \$1,548.00

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 (12 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 14 days after the expiration date of your previous continuation coverage. If premium is not received within 14 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 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.