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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS

PACIFIC UNIVERSITY

2014-1141-1

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 # 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: **Pacific University**
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.**

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Domestic ☐ International ☐ Other - Programs ☐ Physician Assistants

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)	1st Special (E1)
2	Spouse	☐ $ 3,796.00	☐ $ 1,474.00	☐ $ 2,397.00	☐ $ 2,195.00
3	Each Child	☐ $ 1,908.00	☐ $ 741.00	☐ $ 1,204.00	☐ $ 1,104.00

ID Codes		2nd Special (E2)	3rd Special (E3)	4th Special (E4)	5th Special (E5)
2	Spouse	☐ $ 2,132.00	☐ $ 1,241.00	☐ $ 3,796.00	☐ $ 3,871.00
3	Each Child	☐ $ 1,071.00	☐ $ 624.00	☐ $ 1,908.00	☐ $ 1,946.00

ID Codes		6th Special (E6)	7th Special (E7)	8th Special (E8)
2	Spouse	☐ $ 3,871.00	☐$ 3,871.00	☐ $ 3,871.00
3	Each Child	☐ $ 1,946.00	☐$ 1,946.00	☐ $ 1,946.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may include amounts which are retained by your school (to, for example, cover your school's administrative costs associated with offering this health plan) as well as amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/15/2014 to 8/14/2015	☐ 3rd Special	5/6/2014 to 8/30/2014
☐ Fall	8/15/2014 to 12/31/2014	☐ 4th Special	8/6/2014 to 8/05/2015
☐ Spring/Summer	1/1/2015 to 8/14/2015	☐ 5th Special	8/12/2014 to 8/11/2015
☐ 1st Special	1/20/2015 to 8/14/2015	☐ 6th Special	5/6/2014 to 5/05/2015
☐ 2nd Special	1/26/2015 to 8/14/2015	☐ 7th Special	6/1/2014 to 5/31/2015
		☐ 8th Special	6/23/2014 to 6/22/2015

EFFECTIVE AND TERMINATION DATES:
Coverage will become effective on the date the Insurance Company authorized representative receives the application and correct premium payment.

Annual coverage expires 12 months following receipt of your premium or August 14, 2015, whichever is earlier.

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: _____/_____/_____.

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

Dependents only: To request dependent coverage and pay online using a credit card or eCheck, please go to www.uhcsr.com/control and select the "Do you Need a Control Number?" link on the home page. Follow the on screen prompts to request coverage for your dependent. Make sure your email address is correct; we will enter your coverage request into our system and send you an email with instructions for making your premium payment online with a credit card or eCheck.