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UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR GTA/GRA/GA AND THEIR DEPENDENTS

KANSAS BOARD OF REGENTS STATE UNIVERSITIES 2014-200118-3

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 immediately following the expiration of the regular student plan and must be purchased within 60 days after the expiration date of your student coverage. If premium is not received within 60 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.

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 Location: (Please check the school you attend.)

☐	Emporia State University	2014-197-3	☐	Wichita State University	2014-180-3
☐	Kansas State University	2014-470-3	☐	Pittsburg State University	2014-2009-3
☐	University of Kansas	2014-471-3	☐	University of Kansas Medical Center	2014-2070-3

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

Eligibility: Insureds may pay for continuing coverage for a maximum of up to 3 months due to loss of appointment. The Insured has a right to choose to continue benefits as long as the school maintains a plan with our Company. The Insured must exercise this right within 60 days of termination by calling UnitedHealthcare **Student**Resources at 1-888-344-6104 or see the designated contact at your university. Upon request a Certificate of prior creditable coverage will be provide when an employee or their dependent ceases to be covered under this policy.

The Insured must exercise this within 60 days of termination. Application and full premium must be received within 60 days after your expiration date under the student plan from which continuation is allowed. If you do not enroll within 60 days, you are no longer eligible for coverage.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Continuation

Period Codes Monthly (MX)

ID Codes

7	Student	☐ $ 130.00
8	Spouse	☐ $ 522.00
9	All Children	☐ $ 468.00

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $22.00 x 3 months = $66.00

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.