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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR J1 SCHOLARS AND THEIR DEPENDENTS

AUBURN UNIVERSITY AT MONTGOMERY CAMPUS 2014-38-4

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 presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Student's Signature: ______________________________ Date: ____________

Campus Location: Auburn University at Montgomery Campus

☐ **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: ☐ J-1 Scholars Montgomery

ID Codes		Annual (A-)	Fall (F)	Spring (G-)	Summer (S-)
17	Student	☐ $ 1,907.00	☐ $ 664.00	☐ $ 768.00	☐ $ 475.00
18	Spouse	☐ $ 1,907.00	☐ $ 664.00	☐ $ 768.00	☐ $ 475.00
19	Each Child	☐ $ 1,946.00	☐ $ 677.00	☐ $ 784.00	☐ $ 485.00
20	All Children	☐ $ 5,782.00	☐ $ 2,012.00	☐ $ 2,329.00	☐ $ 1,442.00

ID Codes		Monthly (MX)	Weekly (LX)	Daily (NX)
17	Student	☐ $ 159.00	☐ $ 37.00	☐ $ 5.00
18	Spouse	☐ $ 159.00	☐ $ 37.00	☒ $ 5.00
19	Each Child	☐ $ 163.00	☐ $ 37.00	☐ $ 5.00
20	All Children	☐ $ 483.00	☐ $ 111.00	☐ $ 16.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/16/2014	to	8/15/2015
☐ Fall	8/16/2014	to	12/20/2014
☐ Spring	12/21/2014	to	5/16/2015
☐ Summer	5/17/2015	to	8/15/2015

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Coverage expires one month following receipt of your premium for the last month purchased, or August 15, 2015 whichever is earlier. Dependent coverage will be pro-rated to concur with the Student's policy effective date.

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:** _____/_____/_____.

TO CALCULATE YOUR RATE:

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

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.