FRONTIER MEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE ENROLLMENT FORM - AUBURN UNIVERSITY **2014-38-4**

(PLEASE PRINT)

Name: _____ / _____ / _____ ❑ Male ❑ Female
Last First M.I.

Address: _____ City:_____ State or country: _____ Zip Code _____

Date of birth: ____/____/____ Social Security Number: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Home Country: _____ Host Country: _____ Arrival Date: _____

Requested Program Start Date: _____ Host Institution/Center name: _____

Host Institution/Center address: _____ City:_____ State or country: _____

DEPENDENT INFORMATION:

	Last Name	First Name	MI	Date of Birth	Social Security #	
Spouse:	_____	_____	____	_____	_____	❑ Male ❑ Female
Child:	_____	_____	____	_____	_____	❑ Male ❑ Female
Child:	_____	_____	____	_____	_____	❑ Male ❑ Female

NOTICE: Frontier MEDEX will be effective the date the correct amount due is received by UnitedHealthcare StudentResources or the Effective Date of the coverage period, whichever is later.

Signature of Student/Scholar_____ **Date**_____

2014-FMXNRLCARD

PLEASE CHECK ALL APPROPRIATE BOXES: 2014-38-4

AUBURN UNIVERSITY

NOTE: Please visit your school's insurance coverage page at www.uhcsr.com/auburn for the Frontier MEDEX Global Emergency Medical Assistance brochure which includes service descriptions and program exclusions and limitations. All Global Emergency Services must be arranged and provided by Frontier MEDEX, any services not arranged by Frontier MEDEX will not be considered for payment.

Participant Category: Repatriation/Medical Evacuation

Check the Appropriate Box(es)

		Annual (A-)
25.	Student	❑ $103.00
26.	Spouse	❑ $103.00
27.	Each Children	❑ $103.00

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective the date of receipt of this application and correct payment by the Insurance Company.

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 80926
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.