PLEASE NOTE:

THIS DOCUMENT HAS CHANGED. PLEASE SEE THE BACK COVER FOR DETAILS

Processor Date Stamp Received Here

The rates have been updated per state requirements.

UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR BASIC STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF CHICAGO

2014-451-1

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 immediately following the expiration of the regular student plan and must be purchased within 31 days after the expiration date of your student coverage. If premium is not received within 31 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: ______________

☐ **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.

INSURED CATEGORY: ☐ Continuation

Period Codes		Monthly (MX)
ID Codes		
13	Student	☐ $ 259.00
14	Spouse	☐ $ 259.00
15	Each Child	☐ $ 259.00
16	All Children	☐ $ 518.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 08/01/2014 to 08/31/2015

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $259.00 x 3 months = $777.00

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 (6 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 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded.

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.

UnitedHealthcare
A UnitedHealth Group Company

POLICY NUMBER: 2014-451-1

NOTICE:
The benefits contained within have been revised since publication. The revisions are included within the body of the document, and are summarized on the last page of the document for ease of reference.

NOC# 3 (12/18/14)
Updated the rates as per the state requirements