

UNITEDHEALTHCARE INSURANCE COMPANY OF NEW YORK
CONTINUATION ENROLLMENT FORM FOR PART-TIME DOMESTIC STUDENTS AND THEIR DEPENDENTS

PACE UNIVERSITY

2014-869-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> 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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	

NOTICE TO STUDENT: The Insured must enroll and pay the required premium within 60 days of the date coverage terminates under the regular student policy by reason of a qualifying event. Coverage will be effective on the date of the qualifying event provided the enrollment and premium payment is received within the 60 day enrollment and premium payment deadline. If premium is not received within 60 days, the premium will be refunded. By signing, the Insured acknowledges the following: 1) He/She has carefully read the certificate 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 Continuation of Coverage qualifying event eligibility requirements for this coverage as described in the certificate; and 4) If it is later determined that the Insured 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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Student's Signature: _____

Date: _____

