UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR INTERNATIONAL STUDENTS AND THEIR DEPENDENTS

OHIO UNIVERSITY   2015-1103-4

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.

SOCIAL SECURITY #:	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 #:	OHIO.EDU 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Student's Signature: _____   Date: _____

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Campus Attending: Ohio University – Athens 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:

☐ International Undergraduate   ☐ International Graduate
☐ Regular (Internship/Co-op/Study Abroad)   ☐ Medical (HCOM)

ID Codes		Fall (F-)	Spring 1 (G1)	Spring 2 (G2)	Summer (S-)
1	Student	☐ $ 867	☐ $ 867	☐ $ 1,076	☐ $ 459
2	Spouse	☐ $ 867	☐ $ 867	☐ $ 1,076	☐ $ 459
3	One Child	☐ $ 867	☐ $ 867	☐ $ 1,076	☐ $ 459
4	Two or More Children	☐ $ 1,734	☐ $ 1,734	☐ $ 2,152	☐ $ 918

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE/EXPIRATION PERIODS:

☐ Fall   8/16/2015 to 2/14/2016   ☐ Spring 1   2/15/2016 to 8/15/2016   ☐ Spring 2   1/01/2016 to 8/15/2016
☐ Summer   5/11/2016 to 8/15/2016

INSURED CATEGORY: ☐ English Language Program   ☐ Visiting Faculty/Scholars - J-1 Visa

ID Codes		Weekly (LX)	Monthly (MX)
1	Student	☐ $ 33	☐ $ 142
2	Spouse	☐ $ 33	☐ $ 142
3	One Child	☐ $ 33	☐ $ 142
4	Two or More Children	☐ $ 66	☐ $ 284

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE AND TERMINATION DATES:
Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Monthly coverage expires 1 month following receipt of your premium or August 15, 2016, whichever is earlier. Weekly coverage expires 1 week following receipt of your premium or August 15, 2016 whichever is earlier.

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: $142.00 x 3 months = $426.00

Calculation For Total Premium

WEEKLY RATE (ABOVE)	$ _____	MONTHLY RATE (ABOVE)	$ _____
MULTIPLY BY # OF WEEKS TO PURCHASE	X _____	MULTIPLY BY # OF MONTHS TO PURCHASE	X _____

Submit this form to:
Ohio University, Student Health Insurance Administrator
Campus Care, 227 Hudson, Athens, OH 45701
or email to studentinsurance@ohio.edu

To locate this enrollment form online please visit **www.uhcsr.com/ohio**.