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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS

COLLEGE OF WILLIAM AND MARY

2015-1404-2

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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Student's Signature: ____________________ Date: ____________

Campus/School Attending: _____
Please print name of College. Must be completed in order for application to be processed.

☐ **I elect to purchase Injury and Sickness insurance coverage under the College's University's student insurance plan. Below are the choices I have made.**

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ **Domestic** ☐ **International**

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)	Summer (S-)
2	Spouse	☐ $ 1,590.00	☐ $ 665.00	☐ $ 925.00	☐ $ 335.00
3	One Child	☐ $ 1,590.00	☐ $ 665.00	☐ $ 925.00	☐ $ 335.00
4	Two or More Children	☐ $ 3,180.00	☐ $ 1,330.00	☐ $ 1,851.00	☐ $ 670.00
5	Spouse + Two or More Children	☐ $ 4,770.00	☐ $ 1,995.00	☐ $ 2,776.00	☐ $ 1,005.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/1/2015	to	7/31/2016
☐ Fall	8/1/2015	to	12/31/2015
☐ Spring/Summer	1/1/2016	to	7/31/2016
☐ Summer	5/16/2016	to	7/31/2016

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 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.