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UNITEDHEALTHCARE INSURANCE COMPANY
ELECTION FORM FOR DEPENDENTS OF INTERNATIONAL STUDENTS

MINNESOTA STATE UNIVERSITIES **2015-1757-4**

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 election form; 2) Rates are not pro-rated other than as listed on this election 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. A student who requests to cancel coverage under the Policy will receive a refund of unearned premium as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the Insured within 30 days following receipt of the Insured's request for cancellation.

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: ____________

INTERNATIONAL, F-VISA AND J-VISA SCHOLAR STUDENTS MUST CONTACT THEIR SCHOOL'S INTERNATIONAL OFFICE OR STUDENT HEALTH CENTER TO ENROLL IN THIS INSURANCE. DEPENDENTS OF ENROLLED STUDENTS MAY PURCHASE THIS INSURANCE BY FOLLOWING THE PAYMENT INSTRUCTIONS OR DEPENDENT ENROLLMENT INSTRUCTIONS AT THE BOTTOM OF THIS FORM.

CAMPUS LOCATION:

☐ Bemidji State University 2015-1530-4
☐ Minnesota State University-Mankato 2015-1769-4
☐ Minnesota State University-Moorhead 2015-1661-4
☐ St. Cloud State University 2015-1666-4
☐ Southwest Minnesota State University 2015-1675-4
☐ Winona State University 2015-1682-4

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

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ International

ID Codes		Annual (A-)	Spring/Summer (J-)	Summer (S-)
2	Spouse	☐ $ 1,269.00	☐ $ 787.00	☐ $ 368.00
3	One Child	☐ $ 1,269.00	☐ $ 787.00	☐ $ 368.00
4	Two or More Children	☐ $ 2,538.00	☐ $ 1,574.00	☐ $ 736.00
5	Spouse and 2 or More Children	☐ $ 3,807.00	☐ $ 2,361.00	☐ $ 1,104.00

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

☐ Annual	08/15/2015	to	08/14/2016
☐ Spring/Summer	01/01/2016	to	08/14/2016
☐ Summer	05/01/2016	to	08/14/2016

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this election 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.

Dependents only: To request dependent coverage and pay online using a credit card or eCheck, please go to www.uhcsr.com/control and select the "Do you Need a Control Number?" link on the home page. Follow the on screen prompts to request coverage for your dependent. Make sure your email address is correct; we will enter your coverage request into our system and send you an email with instructions for making your premium payment online with a credit card or eCheck.