Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
ELECTION FORM FOR INTERNATIONAL STUDENTS AND THEIR DEPENDENTS

METROPOLITAN STATE UNIVERSITY **2015-1768-4**

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 card; 2) Rates are not pro-rated other than as listed on this election 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. 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 false, incomplete or misleading information may be subject to criminal and/or civil penalties.

Student's Signature: ______________________________ Date: ______________

☐ **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-)
1	Student	☐ $ 1,269.00	☐ $ 787.00	☐ $ 368.00
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/EXPIRATION PERIODS:
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 StudentResources in US dollars. Mail this election card along with premium payment to:
UnitedHealthcare StudentResources
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.