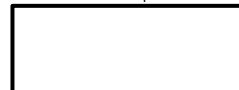


**UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS**



OLD DOMINION UNIVERSITY

2015-284-4

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
SOCIAL SECURITY #:		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: 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: _____

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:

<input type="checkbox"/> English Language Program	<input type="checkbox"/> International
<input type="checkbox"/> Practical Training - International	<input type="checkbox"/> Visiting Faculty/Scholars

ID Codes	Fall (F-)	Spring / Summer (J-)
2 Spouse	<input type="checkbox"/> \$ 709.00	<input type="checkbox"/> \$ 986.00
3 One Child	<input type="checkbox"/> \$ 709.00	<input type="checkbox"/> \$ 986.00
4 Two or more Children	<input type="checkbox"/> \$ 1,418.00	<input type="checkbox"/> \$ 1,972.00
5 Spouse and 2 or more Children	<input type="checkbox"/> \$ 2,127.00	<input type="checkbox"/> \$ 2,958.00

EFFECTIVE/EXPIRATION PERIODS:

Fall 08/01/2015 to 12/31/2015
 Spring/Summer 01/01/2016 to 07/31/2016

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. Mail this enrollment card along with premium payment to:
 UnitedHealthcare **StudentResources**
 PO Box 809026
 Dallas, TX 75380-9026.
 Your cancelled check 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.