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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR ELIGIBLE DEPENDENTS OF INTERNATIONAL STUDENTS
KANSAS BOARD OF REGENTS STATE UNIVERSITIES

2015-200118-4

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 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 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: _______________

Campus Location: (Please check the school you attend.)

☐	Emporia State University	2015-197-4	☐	Fort Hays State University	2015-2005-4
☐	Kansas State University	2015-470-4	☐	Pittsburg State University	2015-2009-4
☐	University of Kansas	2015-471-4	☐	University of Kansas Medical Center	2015-2070-4
☐	Wichita State University	2015-180-4			

☐ **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

		Annual (A-)	Fall (F-)	Spring (G-)	Spring/ Summer (J-)	Summer (S-)
1	Student	☐ $ 1,407.00	☐ $ 586.00	☐ $ 586.00	☐$ 821.00	☐$ 235.00
6	Student + Spouse	☐ $ 2,814.00	☐ $ 1,172.00	☐ $ 1,172.00	☐$ 1,642.00	☐$ 470.00
7	Student + One Child	☐ $ 2,814.00	☐ $ 1,172.00	☐ $ 1,172.00	☐$ 1,642.00	☐$ 470.00
8	Student + Two or more Children	☐ $ 4,221.00	☐ $ 1,759.00	☐ $ 1,759.00	☐$ 2,462.00	☐$ 703.00
9	Student + Spouse + One Child	☐ $ 4,221.00	☐ $ 1,758.00	☐ $ 1,758.00	☐$ 2,463.00	☐$ 705.00
10	Student + Spouse and 2 or more Children	☐ $ 5,628.00	☐ $ 2,345.00	☐ $ 2,345.00	☐$ 3,283.00	☐$ 938.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/1/2015	to 7/31/2016
☐ Fall	8/1/2015	to 12/31/2015
☐ Spring	1/1/2016	to 5/31/2016
☐ Spring/Summer	1/1/2016	to 7/31/2016
☐ Summer	6/1/2016	to 7/31/2016

Credit Card Payments:
If you would like to use a credit card to enroll, please go to www.uhcsr.com/kbor, select your school, click the Enroll Now and follow the instructions.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources 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.