Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS

CHAPMAN UNIVERSITY **2015-670-4**

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 any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

Student's Signature: ______________________________ Date: ______________

Campus/School Attending: _____

Please print name of University. Must be completed in order for application to be processed.

☐ **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

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
2	Spouse	☐ $ 1,455.00	☐ $ 727.50	☐ $ 727.50
3	One Child	☐ $ 1,455.00	☐ $ 727.50	☐ $ 727.50
4	Two or more Children	☐ $ 2,910.00	☐ $ 1,455.00	☐ $ 1,455.00
5	Spouse and 2 or more Children	☐ $ 4,365.00	☐ $ 2,182.50	☐ $ 2,182.50

INSURED CATEGORY: ☐ International Health Sciences Programs

ID Codes		Annual (A-)	Fall (F-)	Spring (G-)	Summer (S-)
7	Spouse	☐ $ 1,455.00	☐ $ 485.00	☐ $ 485.00	☐ $ 485.00
8	One Child	☐ $ 1,455.00	☐ $ 485.00	☐ $ 485.00	☐ $ 485.00
9	Two or more Children	☐ $ 2,910.00	☐ $ 970.00	☐ $ 970.00	☐ $ 970.00
10	Spouse and 2 or more Children	☐ $ 4,365.00	☐ $ 1,455.00	☐ $ 1,455.00	☐ $ 1,455.00

INSURED CATEGORY: ☐ International Law

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
12	Spouse	☐ $ 1,455.00	☐ $ 727.50	☐ $ 727.50
13	One Child	☐ $ 1,455.00	☐ $ 727.50	☐ $ 727.50
14	Two or more Children	☐ $ 2,910.00	☐ $ 1,455.00	☐ $ 1,455.00
15	Spouse and 2 or more Children	☐ $ 4,365.00	☐ $ 2,182.50	☐ $ 2,182.50

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE/EXPIRATION PERIODS:

International				**International Health Sciences Programs**				**International Law**			
☐ Annual	8/17/2015	to	8/24/2016	☐ Annual	8/24/2015	to	8/28/2016	☐ Annual	8/24/2015	to	8/28/2016
☐ Fall	8/17/2015	to	1/31/2016	☐ Fall	8/24/2015	to	1/03/2016	☐ Fall	8/24/2015	to	1/10/2016
☐ Spring/Summer	2/01/2016	to	8/24/2016	☐ Spring	1/04/2016	to	5/01/2016	☐ Spring/Summer	1/11/2016	to	8/28/2016
				☐ Summer	5/02/2016	to	8/28/2016				

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.

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.