

**UNITEDHEALTHCARE GLOBAL EMERGENCY MEDICAL ASSISTANCE  
ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION  
FOR DOMESTIC STUDENTS AND THEIR DEPENDENTS**

**CHAPMAN UNIVERSITY**

**2015-670-4**

<b>PRIMARY INSURED</b> COMPLETE INFORMATION BELOW FOR STUDENT.			
SOCIAL SECURITY #:		OR 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:	
HOME COUNTRY:		HOST COUNTRY:	
REQUESTED PROGRAM START DATE:		HOST INSTITUTION/CENTER NAME:	
HOST INSTITUTION CENTER ADDRESS:			
EMERGENCY CONTACT:		RELATIONSHIP:	PHONE #:

<b>DEPENDENT INFORMATION</b>			
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:

Student's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Campus/School Attending: \_\_\_\_\_

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

**NOTE:** Please visit [www.uhcsr.com/UHCGlobal](http://www.uhcsr.com/UHCGlobal) for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations. All services must be arranged and provided by UnitedHealthcare Global, any services not arranged by UnitedHealthcare Global will not be considered for payment.

PLEASE CHECK ALL APPROPRIATE BOXES.

**INSURED CATEGORY:**                     Standalone Repatriation / Medical Evacuation

- | ID Codes                         | Annual (A-)                        |
|----------------------------------|------------------------------------|
| 16 Student                       | <input type="checkbox"/> \$ 95.00  |
| 17 Spouse                        | <input type="checkbox"/> \$ 95.00  |
| 18 One Child                     | <input type="checkbox"/> \$ 95.00  |
| 19 Two or more Children          | <input type="checkbox"/> \$ 190.00 |
| 20 Spouse and 2 or more Children | <input type="checkbox"/> \$ 285.00 |

**NOTICE:** UnitedHealthcare Global will be effective the date the correct amount due is received by UnitedHealthcare **StudentResources** or the Effective Date of the coverage period, whichever is later.

**EFFECTIVE/EXPIRATION PERIODS:**

Annual    8/17/2015 to 8/28/2016

**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.