

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR ATHENS AND REGIONAL CAMPUS DOMESTIC STUDENTS AND THEIR DEPENDENTS

OHIO UNIVERSITY

2016-1103-2

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 #:		OHIO.EDU 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: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

ATHENS CAMPUS

INSURED CATEGORY: Domestic Undergraduate Domestic Graduate
 Domestic Medical (HCOM)

ID Codes	Fall (F-)	Spring 1 (G1)	Spring 2 (G2)	Summer (S-)
1 Student	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
2 Spouse	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
3 One Child	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
4 Two or More Children	<input type="checkbox"/> \$ 1,976	<input type="checkbox"/> \$ 1,976	<input type="checkbox"/> \$ 2,450	<input type="checkbox"/> \$ 1,156

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:

Fall 8/16/2016 to 2/14/2017 Spring 1 2/15/2017 to 8/15/2017 Spring 2 1/01/2017 to 8/15/2017
 Summer 5/1/2017 to 8/15/2017

REGIONAL CAMPUSES/CENTERS/SATELLITE LOCATIONS

Choose your Campus Location:

<input type="checkbox"/> Cambridge	<input type="checkbox"/> Dublin	<input type="checkbox"/> Proctorville
<input type="checkbox"/> Chillicothe	<input type="checkbox"/> Eastern (St. Clairsville)	<input type="checkbox"/> Southern (Ironton)
<input type="checkbox"/> Circleville	<input type="checkbox"/> Lancaster	<input type="checkbox"/> Zanesville
<input type="checkbox"/> Cleveland	<input type="checkbox"/> Pickerington	<input type="checkbox"/> Other _____

INSURED CATEGORY: Undergraduate Graduate Regional Medical (HCOM)

ID Codes	Fall (F-)	Spring 1 (G1)	Spring 2 (G2)	Summer (S-)
6 Student	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
7 Spouse	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
8 One Child	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 988	<input type="checkbox"/> \$ 1,225	<input type="checkbox"/> \$ 578
9 Two or More Children	<input type="checkbox"/> \$ 1,976	<input type="checkbox"/> \$ 1,976	<input type="checkbox"/> \$ 2,450	<input type="checkbox"/> \$ 1,156

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 Summer 5/1/2017 to 8/15/2017

Submit this form to:

Ohio University, Student Health Insurance Administrator

Campus Care, 227 Hudson, Athens, OH 45701

or email to studentinsurance@ohio.edu or by fax to: 740-593-0699

To locate this enrollment form online please visit www.uhcsr.com/ohio.