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UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

COLLEGE OF WILLIAM AND MARY

2016-1404-2

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 immediately following the expiration of the regular student plan and must be purchased within 31 days after the expiration date of your student coverage. If premium is not received within 31 days, the premium will be refunded. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 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: ______________

Campus/School Attending: _____
Please print name of College. Must be completed in order for application to be processed.

☐ **I elect to purchase Injury and Sickness insurance coverage under the College's student insurance plan. Below are the choices I have made.**

Eligibility: All Insured persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Continuation

Period Codes		Monthly (MX) (90 days maximum)
ID Codes		
11	Student	☐ $ 154.00
12	Spouse	☐ $ 154.00
13	Each Child	☐ $ 154.00
14	All Children	☐ $ 308.00
15	All Dependents	☐ $ 462.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/1/2016 to 7/31/2017

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $154.00 x 3 months = $462.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $_____
Multiply by # of months: _____
Total premium enclosed: $_____

***PLEASE NOTE:** The Continuation Privilege will allow you to purchase up to a maximum of 90 days, but not longer than the current plan year. Incorrect payment amounts will be returned and no coverage will be in effect.

If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (90 days of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school.

Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources name of authorized representative 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.