Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS OF HARD WAIVER STUDENTS

UNIVERSITY OF SOUTHERN MISSISSIPPI 2016-1700-1

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: University of Southern Mississippi
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** ☐ **Visiting Faculty/Scholars**

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
2	Spouse	☐ $ 2,040.00	☐ $ 1,020.00	☐ $ 1,020.00
3	One Child	☐ $ 2,040.00	☐ $ 1,020.00	☐ $ 1,020.00
4	Two or more Children	☐ $ 4,080.00	☐ $ 2,040.00	☐ $ 2,040.00
5	Spouse and 2 or more Children	☐ $ 6,120.00	☐ $ 3,060.00	☐ $ 3,060.00

INSURED CATEGORY: ☐ **Graduate Assistant** ☐ **International Graduate Assistant**
☐ **Residence Assistant**

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
12	Spouse	☐ $ 2,040.00	☐ $ 1,020.00	☐ $ 1,020.00
13	One Child	☐ $ 2,040.00	☐ $ 1,020.00	☐ $ 1,020.00
14	Two or more Children	☐ $ 4,080.00	☐ $ 2,040.00	☐ $ 2,040.00
15	Spouse and 2 or more Children	☐ $ 6,120.00	☐ $ 3,060.00	☐ $ 3,060.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/15/2016 to 8/21/2017
☐ Fall	8/15/2016 to 1/11/2017
☐ Spring/Summer	1/12/2017 to 8/21/2017

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:

Holland Insurance Inc.
PO Box 328
Southaven, MS 38671.

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.