Processor Date Stamp Received Here

NOTE: BENEFITS AND RATES ARE SUBJECT TO REVIEW BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS). WE RESERVE THE RIGHT TO MAKE ANY CHANGES THAT CMS MAY REQUIRE.

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DOMESTIC STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF NORTH TEXAS SYSTEM – DALLAS CAMPUS 2016-203097-1

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 Location: Dallas Campus

☐ **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: ☐ DOMESTIC STUDENTS

ID Codes	Annual (A-)	Fall (F-)	Spring (G-)	Spring/Summer (J-)
1 Student	☐ $ 2,196.00	☐ $ 842.00	☐ $ 794.00	☐ $ 1,354.00
2 Spouse	☐ $ 2,196.00	☐ $ 842.00	☐ $ 794.00	☐ $ 1,354.00
3 One Child	☐ $ 2,196.00	☐ $ 842.00	☐ $ 794.00	☐ $ 1,354.00
4 Two or More Children	☐ $ 4,392.00	☐ $ 1,684.00	☐ $ 1,588.00	☐ $ 2,708.00
5 Spouse + Two or More Children	☐ $ 6,588.00	☐ $ 2,526.00	☐ $ 2,382.00	☐ $ 4,062.00

ID Codes	Summer (S-)
1 Student	☐ $ 560.00
2 Spouse	☐ $ 560.00
3 One Child	☐ $ 560.00
4 Two or More Children	☐ $ 1,120.00
5 Spouse + Two or More Children	☐ $ 1,680.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	8/14/2016	to	8/13/2017
☐ Fall	8/14/2016	to	12/31/2016
☐ Spring	1/1/2017	to	5/12/2017
☐ Spring/ Summer	1/1/2017	to	8/13/2017
☐ Summer	5/13/2017	to	8/13/2017

Annual coverage expires 1 year following receipt of your premium or 08/13/2017, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. Requested Effective Date: _____/_____/_____.

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.

To enroll online: If you would like to use a credit card to enroll, please go to www.uhcsr.com/untdallas and select the Enroll Now link to enroll online.