

**UNITEDHEALTHCARE INSURANCE COMPANY**  
**ENROLLMENT FORM FOR DOMESTIC AND INTERNATIONAL DEPENDENTS**

**UNIVERSITY OF FLORIDA**

**2016-330-2**

<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:	

<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:

**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 or an application containing any false incomplete, or misleading information is guilty of a felony of the third degree.

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

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

Campus/School Attending: University of Florida

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 of Florida's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES.

**INSURED CATEGORY:**             DOMESTIC  
     INTERNATIONAL

ID Codes	Annual (A-)	Fall (F-)	Spring (G-)	Spring/Summer (J-)
7 Spouse	<input type="checkbox"/> \$ 1,812.00	<input type="checkbox"/> \$ 700.00	<input type="checkbox"/> \$ 616.00	<input type="checkbox"/> \$ 1,112.00
8 One Child	<input type="checkbox"/> \$ 1,812.00	<input type="checkbox"/> \$ 700.00	<input type="checkbox"/> \$ 616.00	<input type="checkbox"/> \$ 1,112.00
9 Two or More Children	<input type="checkbox"/> \$ 3,624.00	<input type="checkbox"/> \$ 1,400.00	<input type="checkbox"/> \$ 1,232.00	<input type="checkbox"/> \$ 2,224.00
10 Spouse + Two or More Children	<input type="checkbox"/> \$ 5,436.00	<input type="checkbox"/> \$ 2,100.00	<input type="checkbox"/> \$ 1,848.00	<input type="checkbox"/> \$ 3,336.00

ID Codes	Summer (S-)	Summer 1 (S1)
7 Spouse	<input type="checkbox"/> \$ 496.00	<input type="checkbox"/> \$ 253.00
8 One Child	<input type="checkbox"/> \$ 496.00	<input type="checkbox"/> \$ 253.00
9 Two or More Children	<input type="checkbox"/> \$ 992.00	<input type="checkbox"/> \$ 506.00
10 Spouse + Two or More Children	<input type="checkbox"/> \$ 1,488.00	<input type="checkbox"/> \$ 759.00

**NOTE:** The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

**EFFECTIVE/EXPIRATION PERIODS:**

<input type="checkbox"/> Annual	8/16/2016 to 8/15/2017	<input type="checkbox"/> Summer	5/8/2017 to 8/15/2017
<input type="checkbox"/> Fall	8/16/2016 to 1/3/2017	<input type="checkbox"/> Summer 1	6/26/2017 to 8/15/2017
<input type="checkbox"/> Spring	1/4/2017 to 5/7/2017		
<input type="checkbox"/> Spring/Summer	1/4/2017 to 8/15/2017		

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **StudentResources** name of authorized representative in US dollars. Mail this enrollment card along with premium payment to:

UnitedHealthcare **StudentResources**

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.

**Dependents only:** To request dependent coverage and pay online using a credit card or eCheck, please go to [www.uhcsr.com/control](http://www.uhcsr.com/control) and select the "Do you Need a Control Number?" link on the home page. Follow the on screen prompts to request coverage for your dependent.