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UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR INTERNATIONAL STUDENTS, VISITING FACULTY AND THEIR DEPENDENTS

AUBURN UNIVERSITY **2016-38-4**

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 presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Student's Signature: ______________________________ Date: ____________

Campus Location: Auburn 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: ☐ INTERNATIONAL

ID Codes		Monthly (MX)	Weekly (LX)
1	Student	☐ $ 161.00	☐ $ 38.00
2	Spouse	☐ $ 161.00	☐ $ 38.00
3	One Child	☐ $ 161.00	☐ $ 38.00
4	Two or More Children	☐ $ 319.00	☐ $ 75.00
5	Spouse and 2 or More Children	☐ $ 477.00	☐ $ 112.00

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ VISITING FACULTY/SCHOLARS

ID Codes		Monthly (MX)	Weekly (LX)
6	Student	☐ $ 161.00	☐ $ 38.00
7	Spouse	☐ $ 161.00	☐ $ 38.00
8	One Child	☐ $ 161.00	☐ $ 38.00
9	Two or More Children	☐ $ 319.00	☐ $ 75.00
10	Spouse and 2 or More Children	☐ $ 477.00	☐ $ 112.00

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:

☐ Annual 8/16/2016 to 8/15/2017

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Coverage expires one month following receipt of your premium for the last month purchased, or August 15, 2017, whichever is earlier. Dependent coverage will be pro-rated to concur with the Student's policy effective date.

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:** _____/_____/_____.

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $161.00 x 3 months = $483.00

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.