

UNITEDHEALTHCARE INSURANCE COMPANY  
 ENROLLMENT FORM FOR VISITING SCHOLARS AND THEIR DEPENDENTS  
 KANSAS BOARD OF REGENTS STATE UNIVERSITIES

2016-200118-4

<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 containing false, incomplete or misleading information may be subject to criminal and/or civil penalties.

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

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

Campus Location: (Please check the school you attend.)

- |   |            |  |             |
|---|------------|--|-------------|
| <input type="checkbox"/> Emporia State University | 2016-197-4 | <input type="checkbox"/> Fort Hays State University          | 2016-2005-4 |
| <input type="checkbox"/> Kansas State University  | 2016-470-4 | <input type="checkbox"/> Pittsburg State University          | 2016-2009-4 |
| <input type="checkbox"/> University of Kansas     | 2016-471-4 | <input type="checkbox"/> University of Kansas Medical Center | 2016-2070-4 |
| <input type="checkbox"/> Wichita State University | 2016-180-4 |  |             |

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:**  VISITING SCHOLARS

Monthly (MX)

- |  |                             |        |
|--|-----------------------------|--------|
| 1 Student                                  | <input type="checkbox"/> \$ | 116.00 |
| 6 Student + Spouse                         | <input type="checkbox"/> \$ | 232.00 |
| 7 Student + One Child                      | <input type="checkbox"/> \$ | 232.00 |
| 8 Student + Two or More Children           | <input type="checkbox"/> \$ | 348.00 |
| 9 Student + Spouse + One Child             | <input type="checkbox"/> \$ | 348.00 |
| 10 Student + Spouse + Two or More Children | <input type="checkbox"/> \$ | 464.00 |

**EFFECTIVE/EXPIRATION PERIODS:**

- Annual 8/1/2016 to 7/31/2017

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **StudentResources** 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.

**To pay with a credit card:** If you want to pay for your coverage with a credit card, complete this form and email it to [SIDPremium-CustomerService@uhcsr.com](mailto:SIDPremium-CustomerService@uhcsr.com) or fax it to 469-229-5612. Make sure your email address is correct as we will enter your coverage request into our system and send you an email message with instructions for making your premium payment online with a credit card.