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UNITEDHEALTHCARE GLOBAL EMERGENCY MEDICAL ASSISTANCE ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION

ABRAHAM BALDWIN AGRICULTURAL COLLEGE

2016-566-4

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:	
HOME COUNTRY:	HOST COUNTRY:	
REQUESTED PROGRAM START DATE:	HOST INSTITUTION/CENTER NAME:	
HOST INSTITUTION CENTER ADDRESS:		
EMERGENCY CONTACT:	RELATIONSHIP:	PHONE #:

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:

Student's Signature: ______________________________ Date: ______________

NOTE: Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations. All services must be arranged and provided by UnitedHealthcare Global, any services not arranged by UnitedHealthcare Global will not be considered for payment.

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ Standalone Repatriation/Medical Evacuation

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
6	Student	☐ $ 75.00	☐ $ 31.00	☐ $ 44.00
7	Spouse	☐ $ 75.00	☐ $ 31.00	☐ $ 44.00
8	One Child	☐ $ 75.00	☐ $ 31.00	☐ $ 44.00

NOTICE: UnitedHealthcare Global will be effective the date the correct amount due is received by UnitedHealthcare **Student**Resources or the Effective Date of the coverage period, whichever is later.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/1/2016 to 7/31/2017
☐ Fall 8/1/2016 to 12/31/2016
☐ Spring/Summer 1/1/2017 to 7/31/2017

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

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/usg and select the Enroll Now link to enroll online.