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STUDENT RESOURCES (SPC) LTD., A UNITEDHEALTH GROUP COMPANY
ENROLLMENT FORM FOR STUDENTS

NEW YORK SERVICE CENTER FOR CHINESE STUDY FELLOWS – LOW OPTION 2015-1716-15

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.			
INTERNATIONAL ID #:		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:	

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/School Attending: _____

☐ **I elect to purchase Injury and Sickness insurance coverage. Below are the choices I have made.**

Please check all appropriate boxes.

INSURED CATEGORY: ALL

	Daily (NX) (90 Days Minimum)
Student 24 & Under:	☐ $ 2.01
Student 25 – 29:	☐ $ 3.26
Student 30 +:	☐ $ 6.77

EFFECTIVE AND TERMINATION DATES

NOTICE: Coverage will become effective on the date the correct amount due is received by Student Resources (SPC) Ltd., a UnitedHealth Group Company, or the Requested Effective Date below, whichever is later. Coverage will not be effective prior to July 1, 2015 or extend beyond September 30, 2016. There is a minimum of three (3) months enrollment in this plan. Twelve (12) months is the maximum time coverage can be effective under any policy year.

Requested 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.

To calculate your rate:
Rate x # of days eligible = amount due
Example: $2.01 x 90 days = $180.90

CALCULATION FOR DAILY PREMIUM

Daily premium: $_____

Multiply by # of days: _____

Total premium enclosed: $_____

Payment Instructions: Make check or money order payable to PGH Global in US dollars. Mail this enrollment card along with premium payment to:

PGH Global
67 West Court Street
Doylestown, PA 18901

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.

CHARGE CARD AUTHORIZATION INFORMATION

CHARGE FULL AMOUNT $ _____ ☐ **VISA or** ☐ **MASTERCARD # _____** **Expiration Date** _____-_____ (Month Year) **Security Code** _____

AUTHORIZED SIGNATURE_____ **DATE**_____

OR PAID BY CHECK #_____ **AMOUNT PAID** $_____._____