PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR CONTINUATION STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

UNIVERSITY OF TEXAS - DALLAS

2010-502-1

SOCIAL SECURITY # _______-_____-___________ **or** SCHOOL ID# ____________________

PRIMARY INSURED STUDENT NAME: ______________________________
Last (Family) Name

____
First (Given) Name   Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: ______ - ____ - ______ (Month Day Year) EXPECTED DATE OF GRADUATION: ______ - ______ (Month Year)

PERMANENT ADDRESS: ______________________________
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route | City | County | State | ZIP Code

MAILING ADDRESS: ______________________________
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route | City | County | State | ZIP Code

TELEPHONE # _______ - _______ - _______ E-MAIL ADDRESS: ______________________________

Complete information below for Dependents to be insured. Dependent coverage is available only for Students insured under the Plan.

SPOUSE: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name M/I 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**.

STUDENT'S SIGNATURE: ______________________________ DATE: ____________________

UNIVERSITY OF TEXAS - DALLAS 2010-502-1

ELIGIBILITY: All Insureds who have been continuously Insured under the school's regular student Policy for at least 6 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy are eligible to continue their coverage for a period of not more than 6 months under the school's Policy in effect.

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF TEXAS - DALLAS

❑ **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:

❑ **Continuation**

PERIOD CODES	**Monthly (MX)**
ID CODES	
10 Student	❑ $155.00
11 Spouse	❑ $451.00
12 Each Child	❑ $255.00

CONTINUATION OPTIONAL MAJOR MEDICAL	**Monthly (MX)**
13 Optional Major Medical/Student	❑ $ 84.00
14 Optional Major Medical/Spouse	❑ $ 84.00
15 Optional Major Medical/Each Child	❑ $ 84.00

EFFECTIVE / EXPIRATION PERIODS:

Annual ❑ 08-19-2010 to 08-18-2011

Payment Instructions: Make check or money order payable to UnitedHealthcare Student**Resources** in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. 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. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CALCULATION FOR MONTHLY PREMIUM

MONTHLY RATE (ABOVE)	**$** _____
MULTIPLY BY # OF MONTHS TO PURCHASE	**X** _____
TOTAL PREMIUM ENCLOSED WITHOUT MAJOR MEDICAL	**$** _____

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT $_____ ❑ VISA or ❑ MASTERCARD # _____ Expiration Date Month____Yr___

AUTHORIZED SIGNATURE _____ DATE _____

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