PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

PROCESSOR STAMP DATE RECEIVED HERE

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER HOUSTON

2010-713-1

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: ______________________________

06-NRL

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER HOUSTON 2010-713-1

Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic Coverage at the time of initial enrollment in the Plan. Students may purchase optional coverages for themselves or for themselves and all family members.

Students are required to purchase this insurance and the premium will be added to their tuition billing unless proof of comparable coverage is provided to the school. Students with questions regarding their eligibility / enrollment should contact the campus student insurance office at 713-500-8400.

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER HOUSTON

❑ **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:

- ❑ **DOMESTIC GRADUATE**
- ❑ **DOMESTIC UNDERGRADUATE**
- ❑ **INTERNATIONAL GRADUATE**
- ❑ **INTERNATIONAL UNDERGRADUATE**
- ❑ **VISITING FACULTY/SCHOLARS**

PERIOD CODES	Annual (A-)	Quarterly (QX)	Fall (F-)	Spring (G-)	Summer (S-)
ID CODES					
19 Student	❑ $1,100.00	❑ $ 275.00	❑ $ 395.00	❑ $ 401.00	❑ $ 304.00
20 Spouse	❑ $3,203.00	❑ $ 801.00	❑ $ 1,150.00	❑ $ 1,167.00	❑ $ 886.00
21 All Children	❑ $1,730.00	❑ $ 432.00	❑ $ 621.00	❑ $ 630.00	❑ $ 479.00

OPTIONAL MAJOR MEDICAL (PER PERSON/PER POLICY YEAR)

	Annual (A-)
22 Optional Major Medical/Student	❑ $ 592.00
23 Optional Major Medical/Spouse	❑ $ 592.00
24 Optional Major Medical/Each Child	❑ $ 592.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-30-2010 to 08-29-2011			
Quarterly	❑ 08-30-2010 to 11-29-2010	❑ 11-30-2010 to 02-28-2011	❑ 03-01-2011 to 05-29-2011	❑ 05-30-2011 to 08-29-2011
Fall	❑ 08-30-2010 to 01-09-2011			
Spring	❑ 01-10-2011 to 05-22-2011			
Summer	❑ 05-23-2011 to 08-29-2011			

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.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

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

AUTHORIZED SIGNATURE _____ DATE _____

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