

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



UNIVERSITY OF MIAMI-SCHOOL OF MEDICINE

2008-557-1

SOCIAL SECURITY # _____ - _____ - _____ or SCHOOL ID# _____
PRIMARY INSURED
STUDENT NAME: _____

Last (Family) Name

First (Given) Name

Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ EXPECTED DATE OF GRADUATION: _____ - _____
Check one Month Day Year Month Year

MAILING ADDRESS: _____
House/Building Number and Street Name

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

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

_____ M/I Last (Family) Name

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

_____ M/I Last (Family) Name

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

_____ 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.**

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

STUDENT'S SIGNATURE: _____ DATE: _____

CAMPUS/SCHOOL ATTENDING: University of Miami-School of Medicine

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

Insured Category: All

<u>PERIOD CODES</u>	<u>Annual (A-)</u>	<u>Semi-Annual (IX)</u>
ID CODES		
A Student	<input type="checkbox"/> \$ 1,997.00	<input type="checkbox"/> \$ 1,018.00
B Student & Spouse	<input type="checkbox"/> \$ 7,731.00	<input type="checkbox"/> \$ 3,942.00
C Student & One Child	<input type="checkbox"/> \$ 6,184.00	<input type="checkbox"/> \$ 3,153.00
D Student, Spouse & One Child	<input type="checkbox"/> \$11,918.00	<input type="checkbox"/> \$ 5,077.00
E Each Additional Child	<input type="checkbox"/> \$ 4,187.00	<input type="checkbox"/> \$ 2,135.00

EFFECTIVE / EXPIRATION PERIODS: ALL OTHER

Annual	<input type="checkbox"/> 08-01-2008 to 07-31-2009
First Semi-Annual	<input type="checkbox"/> 08-01-2008 to 01-31-2009
Second Semi-Annual	<input type="checkbox"/> 02-01-2009 to 07-31-2009

Insured Category: Special (Psychology)

<u>PERIOD CODES:</u>	<u>Annual (A)</u>	<u>Semi-/Annual (IX)</u>	<u>Quarterly (OX)</u>	<u>Spring/Summer (J-)</u>	<u>Summer (S-)</u>
ID CODES:					
G Student	<input type="checkbox"/> \$ 1,997.00	<input type="checkbox"/> \$ 1,018.00	<input type="checkbox"/> \$ 509.00	<input type="checkbox"/> \$ 1,267.00	<input type="checkbox"/> \$ 686.00
H Student & Spouse	<input type="checkbox"/> \$ 7,731.00	<input type="checkbox"/> \$ 3,942.00	<input type="checkbox"/> \$ 1,971.00	<input type="checkbox"/> \$ 4,904.00	<input type="checkbox"/> \$ 2,657.00
I Student & One Child	<input type="checkbox"/> \$ 6,184.00	<input type="checkbox"/> \$ 3,153.00	<input type="checkbox"/> \$ 1,577.00	<input type="checkbox"/> \$ 3,923.00	<input type="checkbox"/> \$ 2,215.00
J Student, Spouse & One Child	<input type="checkbox"/> \$11,918.00	<input type="checkbox"/> \$ 6,077.00	<input type="checkbox"/> \$ 3,039.00	<input type="checkbox"/> \$ 7,560.00	<input type="checkbox"/> \$ 4,096.00
K Each Additional Child	<input type="checkbox"/> \$ 4,187.00	<input type="checkbox"/> \$ 2,135.00	<input type="checkbox"/> \$ 1,068.00	<input type="checkbox"/> \$ 2,656.00	<input type="checkbox"/> \$ 1,439.00

EFFECTIVE / EXPIRATION PERIODS: PSYCHOLOGY

Annual	<input type="checkbox"/> 09-01-2008 to 08-31-2009	First Quarter	<input type="checkbox"/> 09-01-2008 to 11-30-2008
First Semi-Annual	<input type="checkbox"/> 09-01-2008 to 02-28-2009	Second Quarter	<input type="checkbox"/> 12-01-2008 to 02-28-2009
Second Semi-Annual	<input type="checkbox"/> 03-01-2009 to 08-31-2009	Third Quarter	<input type="checkbox"/> 03-01-2009 to 05-31-2009
Spring/Summer	<input type="checkbox"/> 01-17-2009 to 08-31-2009	Fourth Quarter	<input type="checkbox"/> 06-01-2009 to 08-31-2009
Summer	<input type="checkbox"/> 05-01-2009 to 08-31-2009		

Payment Instructions: Make check or money order payable to 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 StudentResources, 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 \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month Year
AUTHORIZED SIGNATURE _____	DATE _____	
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____		