UNIVERSITY OF MIAMI
2009-10 DEPENDENTS OF MEDICAL STUDENTS ENROLLMENT FORM
UNITED HEALTHCARE INSURANCE COMPANY Policy #709872

PLEASE PRINT CLEARLY – FAILURE TO PROVIDE ALL INFORMATION MAY DELAY OR VOID YOUR INSURANCE

STUDENT Last Name:

First Name: Middle Initial:

School I.D. # OR Social Security # - -

Date of Birth (Month/day/year) [ ] Male [ ] Female

Mailing Address:

City: State: Zip Home Country

Phone # ( ) EMAIL ADDRESS:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan. Coverage must be purchased at the time of primary insured's enrollment or within 30 days of birth/marriage or arrival in country

Spouse Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 1 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 2 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 3 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

DEPENDENT PREMIUM RATES

	ANNUAL 07/01/2009-06/30/2010	FALL 07/01/2009-12/31/2009	SPRING 1/01/2010-6/30/2010
Spouse			
Under age 25	☐$4,245.00	☐$2,122.00	☐$2,122.00
Ages 25-34	☐$5,175.00	☐$2,580.00	☐$2,580.00
Ages 35-44	☐$6,604.00	☐$3,302.00	☐$3,302.00
Ages 45 & over	☐$8,464.00	☐$4,231.00	☐$4,231.00
Each Child	☐$1,744.00	☐$ 872.00	☐$ 872.00

Premium Calculation

Spouse **$**_____

Each Child _____ **x** **$**_____ **= $**_____

 # Children **x** **premium**

Premium now due **$**_____

METHOD OF PAYMENT

[ ] CHECK [ ] MONEY ORDER Make payable to University of Miami [ ] Credit Card (complete below)

Credit Card Authorization – [ ] MasterCard [ ] Visa Please bill my card for my insurance premium shown above

Cardholder Name (Last/First) _____

Cardholder Number: / / / / / / / / / / / / / / / Expiration Date (mo/year) _____ I _____.

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. Policy renewal is the responsibility of the student / dependent and must be requested prior to the termination of the current policy to prevent a lapse in coverage.

Student's Signature Date

FOR QUESTIONS PLEASE CONTACT:

UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE
ATTN: DR. HILIT MECHABER
P.O. BOX 016960 (R-128) RMSB ROOM 2155B
MIAMI, FL 33101
PHONE 305-243-7978 FAX 305-243-8389

Do not assume insurance is effective until credit card has been charged, or receipt of check has been acknowledged.