UNIVERSITY OF MIAMI

2009-10 MEDICAL STUDENTS ENROLLMENT FORM (2nd-4th Years)

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:

PREMIUM RATES

	ANNUAL 07/01/2009-06/30/2010	FALL 07/01/2009-12/31/2009	SPRING 1/01/2010-6/30/2010
Student	☐$1,907.00	☐$953.00	☐$953.00

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) l .

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.

TO BE COMPLETED AND SIGNED BY DR. HILIT MECHABER OR OTHER MSOM ADMINISTRATOR:

This student is actively enrolled in the Miller School of Medicine. _____

Please note that the student listed above is on an approved leave of absence from the Miller School of Medicine. This student may enroll in the Medical Plan._____