

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



UNIVERSITY OF SAN DIEGO

2007-706-1

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

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

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

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

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

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

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

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

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

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 SAN DIEGO

2007-706-1

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF SAN DIEGO

Please Print Name of College or University Must be completed in order for application to be processed.

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

<u>PERIOD CODES</u>	<u>FALL (F-)</u>	<u>WINTER (W-)</u>	<u>SPRING (G-)</u>	<u>SUMMER (S-)</u>
<u>ID CODES</u>				
A. STUDENT	<input type="checkbox"/> \$367.00	<input type="checkbox"/> \$58.00	<input type="checkbox"/> \$649.00	<input type="checkbox"/> \$220.00
B STUDENT & SPOUSE	<input type="checkbox"/> \$1,204.00	<input type="checkbox"/> \$191.00	<input type="checkbox"/> \$2,126.00	<input type="checkbox"/> \$721.00
C STUDENT & EACH CHILD	<input type="checkbox"/> \$1,097.00	<input type="checkbox"/> \$174.00	<input type="checkbox"/> \$1,938.00	<input type="checkbox"/> \$657.00
D STUDENT, SPOUSE & EACH CHILD	<input type="checkbox"/> \$1,934.00	<input type="checkbox"/> \$307.00	<input type="checkbox"/> \$3,415.00	<input type="checkbox"/> \$1,158.00
E EACH ADDITIONAL CHILD	<input type="checkbox"/> \$730.00	<input type="checkbox"/> \$116.00	<input type="checkbox"/> \$1,289.00	<input type="checkbox"/> \$437.00

<u>PERIOD CODES</u>	<u>ANNUAL (A-)</u>
<u>ID CODES</u>	
A. STUDENT	<input type="checkbox"/> \$996.00
B STUDENT & SPOUSE	<input type="checkbox"/> \$3,265.00
C STUDENT & EACH CHILD	<input type="checkbox"/> \$2,976.00
D STUDENT, SPOUSE & EACH CHILD	<input type="checkbox"/> \$5,245.00
E EACH ADDITIONAL CHILD	<input type="checkbox"/> \$1,980.00

DOMESTIC EFFECTIVE / EXPIRATION PERIODS:

ANNUAL	<input type="checkbox"/> 08-23-2007 TO 08-22-2008
FALL	<input type="checkbox"/> 08-23-2007 TO 01-02-2008
WINTER	<input type="checkbox"/> 01-02-2007 TO 01-23-2008
SPRING	<input type="checkbox"/> 01-02-2008 TO 08-22-2008
SUMMER	<input type="checkbox"/> 06-02-2008 TO 08-22-2008

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** 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 \$ _____		