

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR UNDERGRADUATE STUDENTS, GRADUATE STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



ATHENS STATE UNIVERSITY

2008-1993-91

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: \_\_\_\_\_ - \_\_\_\_\_

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: \_\_\_\_\_ Social Security Number [ ] Male [ ] Female (Check One) Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number [ ] Male [ ] Female (Check One) Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number [ ] Male [ ] Female (Check One) Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number [ ] Male [ ] Female (Check One) Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number [ ] Male [ ] Female (Check One) Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ 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: \_\_\_\_\_

CAMPUS/SCHOOL ATTENDING: ATHENS STATE UNIVERSITY

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:
 Undergraduate       Graduate
PERIOD CODES

Annual (A-)

Spring/Summer (J-)

Summer (S-)

ID CODES**BASIC PLAN - Under Age 30**

A Student	<input type="checkbox"/> \$528.00	<input type="checkbox"/> \$337.00	<input type="checkbox"/> \$117.00
B Spouse	<input type="checkbox"/> \$1,671.00	<input type="checkbox"/> \$1,065.00	<input type="checkbox"/> \$372.00
C All Children	<input type="checkbox"/> \$1,626.00	<input type="checkbox"/> \$1,036.00	<input type="checkbox"/> \$362.00

**BASIC PLAN - Age 30 and Older**

D Student	<input type="checkbox"/> \$627.00	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$140.00
E Spouse	<input type="checkbox"/> \$1,942.00	<input type="checkbox"/> \$1,238.00	<input type="checkbox"/> \$432.00
F All Children	<input type="checkbox"/> \$1,626.00	<input type="checkbox"/> \$1,036.00	<input type="checkbox"/> \$362.00

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-22-2008 through 08-21-2009
Spring/Summer	<input type="checkbox"/> 01-01-2009 through 08-21-2009
Summer	<input type="checkbox"/> 06-01-2009 through 08-21-2009

**Payment Instructions:** Make check or money order payable to United Healthcare 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:

First Risk Advisors  
10 S. Clinton Street, Suite 10  
Doylestown, PA 18901

Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**

**CHARGE CARD AUTHORIZATION PAYMENT INFORMATION**

CHARGE FULL

 VISA or

Expiration Date

Amount

\$

 MASTERCARD #

Month

Year

AUTHORIZED SIGNATURE

DATE

OR

PAID BY CHECK #

AMOUNT PAID

\$