

PLEASE COMPLETE THIS  
FORM IN BLOCK  
LETTER PRINT USE  
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UNITED HEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR UNDERGRADUATE STUDENTS,  
GRADUATE STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

**BIRMINGHAM-SOUTHERN COLLEGE**

**2008-325-91**

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

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

