

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

CENTRAL MICHIGAN UNIVERSITY

2008-369-91

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

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

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

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

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

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

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

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

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

\_\_\_\_\_ 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.**

**NOTICE:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

STUDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

CENTRAL MICHIGAN UNIVERSITY

2008-369-91

CAMPUS/SCHOOL ATTENDING: \_\_\_\_\_

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

**INSURED CATEGORY:**  
(Select Only One)

- Domestic/Undergraduate (DUG)
- International/Undergraduate (IUG)
- Domestic/Graduate (DGR)
- International/Graduate (IGR)

**BASIC PLAN:** (Select all that apply)

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring/Summer (J-)
<b>ID CODES</b>			
A Student	<input type="checkbox"/> \$1,156.00	<input type="checkbox"/> \$ 456.00	<input type="checkbox"/> \$ 700.00
B Spouse	<input type="checkbox"/> \$2,584.00	<input type="checkbox"/> \$1,019.00	<input type="checkbox"/> \$ 1,565.00
C All Children	<input type="checkbox"/> \$2,055.00	<input type="checkbox"/> \$ 811.00	<input type="checkbox"/> \$ 1,244.00

**EFFECTIVE / EXPIRATION PERIODS** (Select one)

- Annual  08-21-2008 to 08-20-2009
- Fall  08-21-2008 to 01-11-2009
- Spring / Summer  01-12-2009 to 08-20-2009

TO BE COMPLETED ONLY IF YOU HAVE OTHER HEALTH INSURANCE		
Group Name: _____	Group # _____	
Insurance Company Name: _____	Policy # _____	
Name of Primary Policyholder: _____	Relationship to Me _____	Ins Co.Phone# ( ) _____

**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 AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date _____ Month - Year
AUTHORIZED SIGNATURE _____		DATE _____
<b>OR</b> PAID BY CHECK # _____		AMOUNT PAID \$ _____