

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



CALHOUN COMMUNITY COLLEGE

2008-201341-91

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

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

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

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

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

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

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

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

CHILD: _____ Social Security Number Male Female Date of Birth : _____
(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: _____

CAMPUS/SCHOOL ATTENDING: CALHOUN COMMUNITY COLLEGE

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

Under Age 30

A Student	<input type="checkbox"/> \$622.00	<input type="checkbox"/> \$390.00	<input type="checkbox"/> \$132.00
B Spouse	<input type="checkbox"/> \$1,966.00	<input type="checkbox"/> \$1,231.00	<input type="checkbox"/> \$416.00
C All Children	<input type="checkbox"/> \$1,510.00	<input type="checkbox"/> \$946.00	<input type="checkbox"/> \$319.00

Age 30 and Older

D Student	<input type="checkbox"/> \$738.00	<input type="checkbox"/> \$462.00	<input type="checkbox"/> \$156.00
E Spouse	<input type="checkbox"/> \$2,284.00	<input type="checkbox"/> \$1,431.00	<input type="checkbox"/> \$483.00
F All Children	<input type="checkbox"/> \$1,913.00	<input type="checkbox"/> \$1,198.00	<input type="checkbox"/> \$405.00

G Optional Major Medical Student	<input type="checkbox"/> \$275.00
H Optional Major Medical Spouse	<input type="checkbox"/> \$275.00
I Optional Major Medical Each Child	<input type="checkbox"/> \$275.00

Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic Coverage at the time of initial enrollment in the Plan. Students may purchase optional coverages for themselves or for themselves and all family members.

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-18-2008 through 08-17-2009
Spring/Summer	<input type="checkbox"/> 01-01-2009 through 08-17-2009
Summer	<input type="checkbox"/> 06-01-2009 through 08-17-2009

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	<input type="checkbox"/> VISA or	Expiration Date
Amount \$ _____	<input type="checkbox"/> MASTERCARD # _____	_____ - _____
		Month Year

AUTHORIZED SIGNATURE _____ **DATE** _____

OR **PAID BY CHECK #** _____ **AMOUNT PAID** \$ _____

