

**PLEASE COMPLETE THIS FORM IN BLOCK LETTER. PRINT USE BLACK INK**

**THE UNITED HEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR  
STUDENTS AND DEPENDENTS**

**IMMACULATA UNIVERSITY**

**2008-201199-91**

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

**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.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

(or of parent if the student is under age 18)

# IMMACULATA UNIVERSITY

2008-201199-91

CAMPUS/SCHOOL ATTENDING: IMMACULATA UNIVERSITY

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:  Resident  Other Non-Resident

**PERIOD CODES**

Annual (A-)      Fall (F-)      Spring/Summer (J-)

**ID CODES**

A Student	<input type="checkbox"/> \$ 668.00	<input type="checkbox"/> \$ 259.00	<input type="checkbox"/> \$ 422.00
B Spouse	<input type="checkbox"/> \$2,336.00	<input type="checkbox"/> \$ 907.00	<input type="checkbox"/> \$1,475.00
C Each Child	<input type="checkbox"/> \$1,169.00	<input type="checkbox"/> \$ 454.00	<input type="checkbox"/> \$ 738.00

Repatriation and Medical Evacuation are included in above rates for Domestic and International students.

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**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-15-2008 through 08-14-2009
Fall	<input type="checkbox"/> 08-15-2008 through 12-31-2008
Spring/Summer	<input type="checkbox"/> 01-01-2009 through 08-14-2009

**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 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 \$ _____	