

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY  
STUDENT PLAN ENROLLMENT FORM FOR



UTAH STATE UNIVERSITY

2008-5856-91

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.**

**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: \_\_\_\_\_

# UTAH STATE UNIVERSITY

2008-5856-91

## Student Plan

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.

<b>INSURED CATEGORY:</b> (Select one)	<input type="checkbox"/> Domestic/Undergraduate <input type="checkbox"/> International/Undergraduate	<input type="checkbox"/> Domestic/Graduate <input type="checkbox"/> International/Graduate
--	---	---

<b>BASIC PLAN:</b> (Select all that apply)			
<b>PERIOD CODES</b>			
	Annual (A-)	Fall (F-)	Spring/Summer (J-)
A Student	<input type="checkbox"/> \$ 1,165.00	<input type="checkbox"/> \$ 444.00	<input type="checkbox"/> \$ 721.00
B Spouse	<input type="checkbox"/> \$ 2,911.00	<input type="checkbox"/> \$ 1,106.00	<input type="checkbox"/> \$ 1,805.00
C Each Child	<input type="checkbox"/> \$ 1,197.00	<input type="checkbox"/> \$ 455.00	<input type="checkbox"/> \$ 742.00
D All Children	<input type="checkbox"/> \$ 2,208.00	<input type="checkbox"/> \$ 839.00	<input type="checkbox"/> \$ 1,369.00

<b>MAJOR MEDICAL:</b> (Select all that apply)	
<b>PERIOD CODES</b>	<b>ONLY AVAILABLE IN CONJUNCTION WITH BASIC PLAN</b>
	Annual (A-)
F Student	<input type="checkbox"/> \$ 250.00
G Spouse	<input type="checkbox"/> \$ 623.00
H Each Child	<input type="checkbox"/> \$ 273.00

<b>EFFECTIVE / EXPIRATION PERIODS</b> (Select one)	
Annual	<input type="checkbox"/> 08-20-2008 to 08-19-2009
Fall	<input type="checkbox"/> 08-20-2008 to 01-04-2009
Spring / Summer	<input type="checkbox"/> 01-05-2009 to 08-19-2009

<b>TO BE COMPLETED ONLY IF YOU HAVE OTHER HEALTH INSURANCE</b>	
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 UnitedHealthcare 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 South Clinton Street, Ste 10, Doylestown, PA 18901-2167. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

<b>CHARGE CARD AUTHORIZATION PAYMENT INFORMATION</b>		Expiration Date
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	____ - ____ Month Year
AUTHORIZED SIGNATURE _____	DATE _____	
<b>OR</b> PAID BY CHECK # _____	AMOUNT PAID \$ _____	