

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

PROCESSOR STAMP DATE RECEIVED HERE



THE UNITED HEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR STUDENTS AND DEPENDENTS

IMMACULATA UNIVERSITY

2009-201199-91

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: _____ - _____ 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

2009-201199-91

CAMPUS/SCHOOL ATTENDING: IMMACULATA UNIVERSITY

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: Resident Other Non-Resident

PERIOD CODES

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

ID CODES

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

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

EFFECTIVE / EXPIRATION PERIODS:

Annual 08-15-2009 through 08-14-2010
 Spring/Summer 01-01-2009 through 08-14-2010

Payment Instructions: All enrollment forms must be submitted to Health Services, who will assess charges directly to the student account. It is the student's responsibility for timely payment.

IU Health Services
Attn: Leslie Pavletich
1145 King Road
PO Box 638
Immaculata, PA 19345

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____ DATE _____ Expiration Date _____
 AUTHORIZED SIGNATURE _____ Month _____ Year _____
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____