

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



NEW JERSEY CITY UNIVERSITY

2009-200049-1

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 Injury & Sickness Plan.

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

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

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

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

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) I declare that I meet eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that I am not eligible, my Premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

FRAUD WARNING - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: _____ DATE: _____

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

