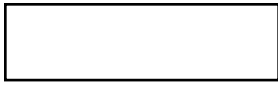


PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
UNIVERSITY OF MARYLAND - COLLEGE PARK

PROCESSOR STAMP DATE RECEIVED HERE



2009-2071-91

STUDENTS UNIVERSITY ID NUMBER

PRIMARY INSURED STUDENT NAME:

Last (Family) Name
First (Given) Name Middle Initial

GENDER: Male Female DATE OF BIRTH: Month Day Year EXPECTED DATE OF GRADUATION: Month Year

PERMANENT ADDRESS: House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route City County State ZIP Code

MAILING 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: Month Day Year

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

CHILD: Social Security Number Male Female Date of Birth: Month Day Year

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

CHILD: Social Security Number Male Female Date of Birth: Month Day Year

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

CHILD: Social Security Number Male Female Date of Birth: Month Day Year

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

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

UNIVERSITY OF MARYLAND - COLLEGE PARK

2009-2071-91

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF MARYLAND - COLLEGE PARK

Please Print Name of College or University Must be completed in order for application to be processed.

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:

EFFECTIVE / EXPIRATION PERIODS:

- | | | |
|---|---|--|
| <input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE <input type="checkbox"/> OTHER: Scholars, Exchange Students & Doctorates | Annual Fall Spring/Summer Summer | <input type="checkbox"/> 08-15-2009 to 08-14-2010 <input type="checkbox"/> 08-15-2009 to 01-14-2010 <input type="checkbox"/> 01-15-2010 to 08-14-2010 <input type="checkbox"/> 06-01-2010 to 08-22-2010 |
|---|---|--|

PERIOD CODES:

Annual (A-)

Fall (F-)

**Spring/
Summer (J-)**

Summer (S-)

ID Codes:

| | | | | |
|----------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|
| A Student | <input type="checkbox"/> \$ 1,186.00 | <input type="checkbox"/> \$ 593.00 | <input type="checkbox"/> \$ 593.00 | <input type="checkbox"/> \$ 264.00 |
| B Student & Spouse | <input type="checkbox"/> \$ 3,900.00 | <input type="checkbox"/> \$ 1,950.00 | <input type="checkbox"/> \$ 1,950.00 | <input type="checkbox"/> \$ 868.00 |
| C Student & All Children | <input type="checkbox"/> \$ 2,466.00 | <input type="checkbox"/> \$ 1,233.00 | <input type="checkbox"/> \$ 1,233.00 | <input type="checkbox"/> \$ 549.00 |
| D Student, Spouse & All Children | <input type="checkbox"/> \$ 5,180.00 | <input type="checkbox"/> \$ 2,590.00 | <input type="checkbox"/> \$ 2,590.00 | <input type="checkbox"/> \$ 1,153.00 |

*The first payment is due upon receipt of application;
 Second payment is due on or before February 15, 2010

OPTIONAL MAJOR MEDICAL

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. Only those students enrolled in Basic coverage may purchase Optional Major Medical coverage.

PERIOD CODES

Annual

ID CODES

| | |
|---------------------------|-----------------------------------|
| E Student | <input type="checkbox"/> \$220.00 |
| F Student & Spouse | <input type="checkbox"/> \$440.00 |
| G Student & One Child | <input type="checkbox"/> \$440.00 |
| H Student, Spouse & Child | <input type="checkbox"/> \$660.00 |
| I Each Additional Child | <input type="checkbox"/> \$220.00 |

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