

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
REFORMED THEOLOGICAL SEMINARY

PROCESSOR STAMP DATE RECEIVED HERE

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2011-2248-2

PRIMARY INSURED Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH YEAR	
PERMANENT ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

DEPENDENT INFORMATION: Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH DAY YEAR	
First (Given) Name	Middle Initial:	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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: _____

DATE: _____

REFORMED THEOLOGICAL SEMINARY

2011-0-1

CAMPUS/SCHOOL ATTENDING: _____
 Please Print Name of Seminary Must be completed in order for application to be processed.

I elect to purchase Injury and Sickness insurance coverage under the Seminary's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES
INSURED CATEGORY: Any applicable category

FULL-TIME

	Annual (A-)	1st Semi-Annual (I1)	2nd Semi-Annual (I2)
ID CODES FOR CHARLOTTE CAMPUS STUDENTS			
01 Student	<input type="checkbox"/> \$ 916.00	<input type="checkbox"/> \$ 467.00	<input type="checkbox"/> \$ 467.00
02 Spouse	<input type="checkbox"/> \$ 2,012.00	<input type="checkbox"/> \$ 1,026.00	<input type="checkbox"/> \$ 1,026.00
03 Each Child	<input type="checkbox"/> \$ 1,149.00	<input type="checkbox"/> \$ 586.00	<input type="checkbox"/> \$ 586.00

PART-TIME

	Annual (A-)	1st Semi-Annual (I1)	2nd Semi-Annual (I2)
ID CODES FOR CHARLOTTE CAMPUS STUDENTS			
04 Student	<input type="checkbox"/> \$ 916.00	<input type="checkbox"/> \$ 467.00	<input type="checkbox"/> \$ 467.00
05 Spouse	<input type="checkbox"/> \$ 1,992.00	<input type="checkbox"/> \$ 1,016.00	<input type="checkbox"/> \$ 1,016.00
06 Each Child	<input type="checkbox"/> \$ 1,140.00	<input type="checkbox"/> \$ 581.00	<input type="checkbox"/> \$ 581.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual 08-24-2011 to 08-23-2012
 1st Semi-Annual 08-24-2011 to 01-30-2012
 2nd Semi-Annual 01-31-2012 to 08-23-2012

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** name of authorized representative in US dollars. Mail this enrollment card along with premium payment to:
 UnitedHealthcare **StudentResources**
 PO Box 809026
 Dallas, TX 75380-9026.
 Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

To enroll online: If you would like to use a credit card to enroll, please go to www.uhcsr.com, and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then select the Enroll Now link to enroll online.