

REFORMED THEOLOGICAL SEMINARY  
CONTINUATION STUDENT INSURANCE ENROLLMENT CARD  
(PLEASE PRINT)

UnitedHealthcare Insurance Company  
2010-2248-2

Student's Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI

Male  Female

Permanent US Address \_\_\_\_\_  
Street or PO Box City State Zip

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Expected Graduation Date: Month \_\_\_\_\_ Date \_\_\_\_\_ E-Mail address \_\_\_\_\_

[List Dependents to be insured below. Dependent coverage is available only if the student is also insured under the Plan and cannot exceed coverage purchased by the student.

	Last Name	First Name	MI	Date of Birth	Social Security #
--	-----------	------------	----	---------------	-------------------

Spouse: \_\_\_\_\_

Child: \_\_\_\_\_

Child: \_\_\_\_\_ ]

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. It is the student's responsibility for timely renewal payments. By signing below, 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; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE CHECK ALL APPROPRIATE BOXES:**

**2010-2248-2**

**ELIGIBILITY:** All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy and who are not eligible for other insurance coverage including Medicare. The maximum length of coverage under the continuation Plan is 9 months. Coverage date not to extend beyond **August 23, 2011** at the rate listed.

**Insured Category: CONTINUATION**

**Please check the**

**Appropriate Box(es)                      Monthly (MX)**

**FULL TIME STUDENTS**

- 5. Continuing Student             \$0.00
- 6. Spouse                             \$0.00
- 6. Each Child                       \$0.00

**PART TIME STUDENTS**

- 7. Continuing Student             \$0.00
- 8. Spouse                             \$0.00
- 9. Each Child                       \$0.00

Effective / Expiration Periods: **Monthly**

Annual  **08-24-2010 to 08-23-2011**

**Payment Instructions:** Make check or money order payable to Student Insurance, 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 UnitedHealthcare StudentResources, PO Box 809026, Dallas, TX 75380-9026. 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.**

<b>CHARGE CARD AUTHORIZATION</b>	
CHARGE FULL AMOUNT \$ _____	EXP DATE _____ / _____
VISA/MASTERCARD # _____	
SIGNATURE OF CARDHOLDER _____	