

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

REFORMED THEOLOGICAL SEMINARY

UNITED HEALTHCARE INSURANCE COMPANY CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

2010-2248-1

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 Plan.

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

_____ M/I Last (Family) Name

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

_____ M/I Last (Family) Name

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

_____ M/I Last (Family) Name

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

_____ M/I Last (Family) Name

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

_____ 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: _____

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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. You must enroll within 31 days of the termination date of coverage under the basic medical expense plan. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the Insured must purchase coverage under the new policy as chosen by the school.

PLEASE CHECK ALL APPROPRIATE BOXES

CAMPUS LOCATION:

- Orlando, FL
 Atlanta, GA
 Jackson, MS
 Washington D.C.

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

INSURED CATEGORY: CONTINUATION

FULL TIME STUDENTS

PART-TIME STUDENTS

PERIOD CODES

Monthly (MX)

ID CODES

ID CODES

Monthly (MX)

- 5 Student** \$104.00
6 Spouse \$229.00
7 Each Child \$131.00

- 8 Student** \$103.00
9 Spouse \$227.00
10 Each Child \$130.00

EFFECTIVE / EXPIRATION PERIODS: Annual 08-24-2010 to 08-23-2011

<p>Payment Instructions: Make check or money order payable to Student Resources 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 payments whether or not a renewal notice is received.</p>	<p style="text-align: center;">To Calculate Your Rate: Rate x # of months eligible = Amount Due Example: \$104.00 x 3 months = \$312.00</p> <hr/> <p style="text-align: center;">CALCULATION FOR MONTHLY PREMIUM</p> <p>MONTHLY RATE (ABOVE) \$ _____</p> <p>MULTIPLY BY # OF MONTHS TO PURCHASE X _____</p> <p>TOTAL PREMIUM ENCLOSED \$ _____</p>
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PAYMENT INFORMATION		Expiration Date
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	_____ - Month Year
AUTHORIZED SIGNATURE _____		DATE _____
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____		