

**PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK**

**UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS OF
INTERNATIONAL STUDENTS**

MOUNT MARY COLLEGE

2010-1537-4

SOCIAL SECURITY # _____ - ____ - _____ **or** SCHOOL ID# _____
 PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name

_____ First (Given) Name Middle Initial

GENDER: Male Female Check one DATE OF BIRTH: _____ - ____ - _____ EXPECTED DATE OF GRADUATION: _____ - ____ - _____
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

_____ First (Given) Name M/I Last (Family) Name
 CHILD: _____ - ____ - _____ Male Female Date of Birth : _____ - ____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
 CHILD: _____ - ____ - _____ Male Female Date of Birth : _____ - ____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
 CHILD: _____ - ____ - _____ Male Female Date of Birth : _____ - ____ - _____
Social Security Number (Check One) Month Day Year

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

MOUNT MARY COLLEGE

2010-1537-4

CAMPUS/SCHOOL ATTENDING: Mount Mary College

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: International

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring/Summer (J-)
ID CODES			
B Spouse	<input type="checkbox"/> \$2,624.00	<input type="checkbox"/> \$1,100.00	<input type="checkbox"/> \$1,524.00
C Each Child	<input type="checkbox"/> \$1,968.00	<input type="checkbox"/> \$ 825.00	<input type="checkbox"/> \$1,143.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-01-2010 to 07-31-2011
Fall	<input type="checkbox"/> 08-01-2010 to 12-31-2010
Spring/Summer	<input type="checkbox"/> 01-01-2011 to 07-31-2011

Payment Instructions: Make check or money order payable to UnitedHealthcare **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 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.

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 \$ _____