

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

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



**HOUGHTON COLLEGE**

**2009-823-1 & 2009-823-2**

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

PERMANENT U.S. 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: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  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.**

**NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act; which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the sated value of the claim for each such violation.

STUDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**HOUGHTON COLLEGE**

**2009-823-1 & 2009-823-2**

CAMPUS/SCHOOL ATTENDING: Houghton College

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

**PLEASE CHECK ALL APPROPRIATE BOXES**

**PLAN 1 - INJURY AND SICKNESS (2009-823-1)**

**INSURED CATEGORY:**     All

<b><u>PERIOD CODES</u></b>	<b>Annual (A-)</b>	<b>Fall</b>	<b>Spring (G-)</b>
<b><u>ID CODES</u></b>			
A Student	<input type="checkbox"/> \$ 772.00	<input type="checkbox"/> \$ 304.00	<input type="checkbox"/> \$ 483.00
B Spouse	<input type="checkbox"/> \$ 1,158.00	<input type="checkbox"/> \$ 456.00	<input type="checkbox"/> \$ 725.00
C Each Child	<input type="checkbox"/> \$ 1,158.00	<input type="checkbox"/> \$ 456.00	<input type="checkbox"/> \$ 725.00

**OPTIONAL CATASTROPHIC MEDICAL - Plan 1 Only**  
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 Plan 1 basic coverage may purchase Optional Catastrophic Medical coverage.

<b><u>PERIOD CODES</u></b>	<b>Annual (A-)</b>
<b><u>ID CODES</u></b>	
A Student (Under age 26)	<input type="checkbox"/> \$ 411.00
A Student (Age 26 and Older)	<input type="checkbox"/> \$ 638.00

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**PLAN 2 - INJURY ONLY (2009-823-2)**

**INSURED CATEGORY:**     All

<b><u>PERIOD CODES</u></b>	<b>Annual (A-)</b>	<b>Fall</b>	<b>Spring (G-)</b>
<b><u>ID CODES</u></b>			
A Student	<input type="checkbox"/> \$ 80.00	<input type="checkbox"/> \$ 32.00	<input type="checkbox"/> \$ 50.00

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**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-13-2009 to 08-12-2010
Fall	<input type="checkbox"/> 08-13-2009 to 12-31-2009
Spring	<input type="checkbox"/> 01-01-2010 to 08-12-2010

***PLEASE DO NOT SEND PAYMENT WITH THE ENROLLMENT FORM.  
THE CHARGE WILL BE PLACED ON THE STUDENT'S ACCOUNT.***