

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



HOUGHTON COLLEGE

2010-823-1 & 2010-823-2

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

2010-823-1 & 2010-823-2

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 (2010-823-1)

INSURED CATEGORY: All

<u>PERIOD CODES</u>	Annual (A-)	Fall	Spring (G-)
ID CODES			
A Student	<input type="checkbox"/> \$ 865.00	<input type="checkbox"/> \$ 341.00	<input type="checkbox"/> \$ 541.00
B Spouse	<input type="checkbox"/> \$ 1,297.00	<input type="checkbox"/> \$ 511.00	<input type="checkbox"/> \$ 812.00
C Each Child	<input type="checkbox"/> \$ 1,297.00	<input type="checkbox"/> \$ 511.00	<input type="checkbox"/> \$ 812.00

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.

<u>PERIOD CODES</u>	Annual (A-)
ID CODES	
A Student (Under age 26)	<input type="checkbox"/> \$ 460.00
A Student (Age 26 and Older)	<input type="checkbox"/> \$ 715.00

PLAN 2 - INJURY ONLY (2010-823-2)

INSURED CATEGORY: All

<u>PERIOD CODES</u>	Annual (A-)	Fall	Spring (G-)
ID CODES			
A Student	<input type="checkbox"/> \$ 90.00	<input type="checkbox"/> \$ 35.00	<input type="checkbox"/> \$ 56.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-13-2010 to 08-12-2011
Fall	<input type="checkbox"/> 08-13-2010 to 12-31-2010
Spring	<input type="checkbox"/> 01-01-2011 to 08-12-2011

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