

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR
PART-TIME STUDENTS AND DEPENDENTS
SUNY PLATTSBURGH

PROCESSOR STAMP DATE RECEIVED HERE



2009-200260-1

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

PERMANENT 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 injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

STUDENT'S SIGNATURE: _____ DATE: _____

SUNY Plattsburgh

2009-200260-1

CAMPUS/SCHOOL ATTENDING: _____

I elect to purchase Injury and Sickness insurance coverage under the SUNY Plattsburgh student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: FULL-TIME (HARD WAIVER)
 PART-TIME (VOLUNTARY)

PERIOD CODES

<u>ID CODES</u>	<u>Annual (A-)</u>	<u>Fall (F)</u>	<u>Spring/Summer (J-)</u>
A Student	<input type="checkbox"/> \$ 366.00	<input type="checkbox"/> \$183.00	<input type="checkbox"/> \$183.00
B Student & Spouse	<input type="checkbox"/> \$ 1,084.00	<input type="checkbox"/> \$542.00	<input type="checkbox"/> \$542.00
C Student & All Children	<input type="checkbox"/> \$ 872.00	<input type="checkbox"/> \$436.00	<input type="checkbox"/> \$436.00
D Student, Spouse All Children	<input type="checkbox"/> \$ 1,590.00	<input type="checkbox"/> \$795.00	<input type="checkbox"/> \$795.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-15-2009-to 08-14-2010
Fall	<input type="checkbox"/> 08-15-2009 to 01-21-2010
Spring/Summer	<input type="checkbox"/> 01-22-2010 to 08-14-2010

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 \$ _____ VISA or MASTERCARD # _____ Expiration Date _____
 Month Year

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____