

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



2010-200260-1

BANNER 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.**

FRAUD 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 stated value of the claim for each such violation.

STUDENT'S SIGNATURE: _____ DATE: _____

SUNY Plattsburgh

2010-200260-1

CAMPUS/SCHOOL ATTENDING: SUNY - PLATTSBURGH

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

PLEASE CHECK ALL APPROPRIATE BOXES

- INSURED CATEGORY:** FULL-TIME (HARD WAIVER) DEPENDENTS
 PART-TIME (VOLUNTARY) STUDENT AND DEPENDENTS

PERIOD CODES

<u>ID CODES</u>	<u>Annual (A-)</u>	<u>Fall (F)</u>	<u>Spring/Summer (J-)</u>	<u>Summer (S-)</u>
A Student	<input type="checkbox"/> \$ 420.00	<input type="checkbox"/> \$ 210.00	<input type="checkbox"/> \$ 210.00	<input type="checkbox"/> \$ 42.00
B Student & Spouse	<input type="checkbox"/> \$ 1,246.00	<input type="checkbox"/> \$ 623.00	<input type="checkbox"/> \$ 623.00	<input type="checkbox"/> \$ 123.00
C Student & All Children	<input type="checkbox"/> \$ 1,002.00	<input type="checkbox"/> \$ 501.00	<input type="checkbox"/> \$ 501.00	<input type="checkbox"/> \$ 99.00
D Student, Spouse All Children	<input type="checkbox"/> \$ 1,828.00	<input type="checkbox"/> \$ 914.00	<input type="checkbox"/> \$ 914.00	<input type="checkbox"/> \$ 180.00

EFFECTIVE / EXPIRATION PERIODS:

- Annual 08-15-2010-to 08-14-2011
Fall 08-15-2010 to 01-14-2011
Spring/Summer 01-15-2011 to 08-14-2011
Summer 07-10-2011 to 08-14-2011

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**
P. O. 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 payment whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL VISA or MASTERCARD # _____ Expiration Date _____
AMOUNT \$ _____
Month Year _____
AUTHORIZED SIGNATURE: _____ DATE _____
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____