

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK
ENROLLMENT FORM FOR
DEPENDENTS ONLY
SUNY INSTITUTE OF TECHNOLOGY-UTICA/ROME

PROCESSOR STAMP DATE RECEIVED HERE



2008-2079-1

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 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: _____

CAMPUS/SCHOOL ATTENDING: SUNY INSTITUTE OF TECHNOLOGY-UTICA/ROME

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

PLEASE CHECK ALL APPROPRIATE BOXES
INSURED CATEGORY:

ALL

Basic

<u>PERIOD CODES</u>	<u>Annual (A-)</u>	<u>Fall (F-)</u>	<u>Spring (S-)</u>
ID CODES			
B Dependent Under Age 26	<input type="checkbox"/> \$ 424.00	<input type="checkbox"/> \$ 212.00	<input type="checkbox"/> \$ 212.00
C Dependent Age 26 & Older	<input type="checkbox"/> \$ 624.00	<input type="checkbox"/> \$ 312.00	<input type="checkbox"/> \$ 312.00

OPTIONAL CATASTROPHIC

<u>PERIOD CODES</u>	<u>Annual (A-)</u>
ID CODES	
D Student Under Age 26	<input type="checkbox"/> \$ 416.00
E Student Age 26 & Older	<input type="checkbox"/> \$ 624.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-15-2008 to 01-01-2009
Fall	<input type="checkbox"/> 08-15-2008 to 08-14-2009
Spring	<input type="checkbox"/> 01-02-2009 to 08-14-2009

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. You may also send your enrollment card by email to sidpremium-dataentry@uhcsr.com or fax to 469-229-5612. 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 \$ _____	