

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK CONTINUATION ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



BINGHAMTON UNIVERSITY

2010-890-1

SCHOOL ID#/ (BU-B#) \_\_\_\_\_

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: \_\_\_\_\_

BINGHAMTON UNIVERSITY

2010-890-1

CAMPUS/SCHOOL ATTENDING: Binghamton University

ELIGIBILITY: All Insured Persons who have been continuously insured under the school's regular student Policy for at least 6 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy and who are not eligible for other insurance coverage including Medicare. The maximum length of coverage under the continuation Plan is 6 months.

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 CLASSIFICATION:**  
Continuation

6 Month Continuation

<b>PERIOD CODES</b>	<b>Monthly(MX-)</b>
<b>ID CODES</b>	
G Student	<input type="checkbox"/> \$ 56.00
H Spouse	<input type="checkbox"/> \$ 84.00
I Each Child	<input type="checkbox"/> \$ 84.00
J All Children	<input type="checkbox"/> \$ 128.00

**EFFECTIVE / EXPIRATION PERIODS:**

Continuation  
Annual  08-15-2010 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**, 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 \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month - Year
AUTHORIZED SIGNATURE _____	DATE _____	
<b>OR</b> PAID BY CHECK # _____	AMOUNT PAID \$ _____	