

**PLEASE COMPLETE  
THIS FORM IN BLOCK  
LETTER PRINT USE  
BLACK INK**

**UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK  
ENROLLMENT FORM FOR**



**MEDAILLE COLLEGE**

**2008-849-72**

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.**

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: \_\_\_\_\_

CAMPUS/SCHOOL ATTENDING: MEDAILLE COLLEGE

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**

<u>PERIOD CODES</u> <u>ID CODES</u>	Annual (A-)	Spring (G-)	Summer (J-)
A Student	<input type="checkbox"/> \$ 734.00	<input type="checkbox"/> \$ 498.00	<input type="checkbox"/> \$ 222.00
B Spouse	<input type="checkbox"/> \$2,562.00	<input type="checkbox"/> \$1,740.00	<input type="checkbox"/> \$ 773.00
C Each Child	<input type="checkbox"/> \$1,280.00	<input type="checkbox"/> \$ 869.00	<input type="checkbox"/> \$ 386.00

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 09-01-2008 to 08-31-2009
Spring	<input type="checkbox"/> 01-01-2009 to 08-31-2009
Summer	<input type="checkbox"/> 05-15-2009 to 08-31-2009

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **Student**Resources 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 **Student**Resources, 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.

<b>CHARGE CARD AUTHORIZATION PAYMENT INFORMATION</b>		
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 \$ _____