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

PROCESSOR STAMP DATE RECEIVED HERE

BINGHAMTON UNIVERSITY

2008-890-1

SCHOOL ID#/ (BU-B#) ____________________

PRIMARY INSURED STUDENT NAME: ______________________________
Last (Family) Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: ______ - ____ - ______ (Month Day Year) EXPECTED DATE OF GRADUATION: ______ - _____ (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: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :______-______-______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :______-______-______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :______-______-______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :______-______-______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :______-______-______ (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: ____________________

06-NRL

BINGHAMTON UNIVERSITY 2008-890-1

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

PERIOD CODES	**Monthly(MX-)**
ID CODES	
K Student	❑ $ 65.00
L Spouse	❑ $ 98.00
M Each Child	❑ $ 98.00

EFFECTIVE / EXPIRATION PERIODS:

Continuation

Annual ❑ 08-15-2008 to 08-14-2009

CALCULATION FOR MONTHLY PREMIUM

MONTHLY RATE (ABOVE) **$** ____________________

MULTIPLY BY # OF MONTHS TO PURCHASE **X** ____________________

TOTAL PREMIUM ENCLOSED **$** ____________________

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.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT $____________________ ❑ VISA or ❑ MASTERCARD #____

Expiration Date _____ - _____ Month Year

AUTHORIZED SIGNATURE____ DATE ______________

OR PAID BY CHECK #____ AMOUNT PAID $________________