

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

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



BINGHAMTON UNIVERSITY

2008-890-1

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: _____

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

2008-890-1

CAMPUS/SCHOOL ATTENDING: Binghamton University

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:

Full-Time
Part-Time
Graduate

PERIOD CODES

Annual (A-)

Fall (F-)

Spring (G-)

Summer (S-)

ID CODES

B Spouse	<input type="checkbox"/> \$ 767.00	<input type="checkbox"/> \$ 334.00	<input type="checkbox"/> \$ 443.00	<input type="checkbox"/> \$ 193.00
C Each Child	<input type="checkbox"/> \$ 767.00	<input type="checkbox"/> \$ 334.00	<input type="checkbox"/> \$ 443.00	<input type="checkbox"/> \$ 193.00

OPTIONAL MAJOR MEDICAL

PERIOD CODES

Annual (A-)

ID CODES

D Student Under Age 26	<input type="checkbox"/> \$ 259.00
E Student Age 26 & Older	<input type="checkbox"/> \$ 391.00

EFFECTIVE / EXPIRATION PERIODS:

Fall	<input type="checkbox"/> 08-15-2008 to 01-15-2009
Annual	<input type="checkbox"/> 08-15-2008 to 08-14-2009
Spring	<input type="checkbox"/> 01-16-2009 to 08-14-2009
Summer	<input type="checkbox"/> 05-15-2009 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. 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 \$ _____	