



STUDENT HEALTH INSURANCE ENROLLMENT FORM
MOUNT MARY COLLEGE POLICY
StudentResources (underwritten by United HealthCare)

STUDENT'S NAME: _____
(Please Print Clearly) LAST FIRST M.I.

SOCIAL SECURITY #: _____ OR SCHOOL ID #: _____

BIRTH DATE: _____ GENDER: _____

MAILING ADDRESS (address where your insurance call will be mailed) _____

PERMANENT ADDRESS: _____

E-MAIL ADDRESS: _____ PHONE /CELL #: _____ ()

PREMIUM RATES (50,000 COVERAGE)

_____ SPRING/SUMMER COVERAGE: (coverage from 1/1/10 to 7/31/10) \$471

CHECK #: _____ (Payable to Mount Mary College) OR

_____ I AUTHORIZE MOUNT MARY TO BILL MY STUDENT ACCOUNT

THIS WAIVER FORM MUST BE RETURNED BY February 1, 2010 TO: Associate Dean for Student Affairs, 2900 N. Menomonee River Parkway, Milwaukee, WI 53222 or dropped off at Caroline Hall 147.

NOTICE TO STUDENT: The Mount Mary College Student Health Insurance Plan is offered by United HealthCare StudentResources and is not provided, administered, or guaranteed by the College. Coverage will be effective the date the correct premium and enrollment form are received by the College or the effective date of the coverage period, which ever is later. Student enrolled prior to the College's enrollment deadline may have coverage as of the effective date of the coverage period. By signing below, the student acknowledges the following: 1) She has carefully read the brochure; 2) Rates are not pro-rated; 3) She meets the eligibility requirements for this coverage as described in the brochure; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Premium is not refunded except for ineligibility or entrance into the armed forces.

SIGNATURE OF STUDENT _____ DATE _____

Your ID Card will be mailed by United HealthCare StudentResources upon receipt of your enrollment. You can print a temporary card from www.uhcrs.com.