

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

**UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR CONTINUATION STUDENTS AND THEIR
DEPENDENTS**



MOUNT MARY COLLEGE

2010-1537-3

SOCIAL SECURITY # _____ - _____ - _____ **or** SCHOOL ID# _____

PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name

_____ First (Given) Name _____ Middle Initial _____

GENDER: Male Female Other 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.**

STUDENT'S SIGNATURE: _____ DATE: _____

MOUNT MARY COLLEGE

2010-1537-3

ELIGIBILITY: All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than nine months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

CAMPUS/SCHOOL ATTENDING: MOUNT MARY 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:

Continuation

PERIOD CODES **Monthly (MX)**

ID CODES

D Student	<input type="checkbox"/> \$ 164.00
E Spouse	<input type="checkbox"/> \$ 328.00
F Each Child	<input type="checkbox"/> \$ 246.00

EFFECTIVE / EXPIRATION PERIODS:

Annual 08-01-2010 to 07-31-2011

<p>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.</p>	<p style="text-align: center;">To Calculate Your Rate: Rate x # of months eligible = Amount Due Example: \$164.00 x 3 months - \$492.00</p> <hr/> <p style="text-align: center;">CALCULATION FOR MONTHLY PREMIUM</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 70%;">MONTHLY RATE (ABOVE)</td> <td style="width: 30%; text-align: right;">\$ _____</td> </tr> <tr> <td>MULTIPLY BY # OF MONTHS TO PURCHASE</td> <td style="text-align: right;">X _____</td> </tr> <tr> <td>TOTAL PREMIUM ENCLOSED</td> <td style="text-align: right;">\$ _____</td> </tr> </table>	MONTHLY RATE (ABOVE)	\$ _____	MULTIPLY BY # OF MONTHS TO PURCHASE	X _____	TOTAL PREMIUM ENCLOSED	\$ _____
MONTHLY RATE (ABOVE)	\$ _____						
MULTIPLY BY # OF MONTHS TO PURCHASE	X _____						
TOTAL PREMIUM ENCLOSED	\$ _____						

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 \$ _____.		