PROCESSOR STAMP DATE RECEIVED HERE

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

2010-1537-4

SOCIAL SECURITY # _______-_____-___________ or SCHOOL ID# ______________________

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 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**.

STUDENT'S SIGNATURE: ______________________________ DATE: ______________________

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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	❑ $ 164.00
E Spouse	❑ $ 328.00
F Each Child	❑ $ 246.00

EFFECTIVE / EXPIRATION PERIODS:

Annual ❑ 08-01-2010 to 07-31-2011

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.**

To Calculate Your Rate:

Rate x # of months eligible = Amount Due

Example: $164.00 x 3 months - $492.00

CALCULATION FOR MONTHLY PREMIUM

MONTHLY RATE (ABOVE) $ ____________

MULTIPLY BY # OF MONTHS TO PURCHASE X ____________

TOTAL PREMIUM ENCLOSED $ ____________

PAYMENT INFORMATION

CHARGE FULL AMOUNT $ ____________ ❑ VISA or ❑ MASTERCARD # ____________ Expiration Date ____ - ____ Month Year

AUTHORIZED SIGNATURE ____________ DATE ____________

OR PAID BY CHECK # ____________ AMOUNT PAID $______.____