

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS
SUNY DELHI

PROCESSOR STAMP DATE RECEIVED HERE

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2011-201879-1

PRIMARY INSURED Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH / YEAR	
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

DEPENDENT INFORMATION: Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	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 stated value of the claim for each such violation.

STUDENT'S SIGNATURE: _____

DATE: _____

CAMPUS/SCHOOL ATTENDING: SUNY DELHI

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: FULL-TIME

PERIOD CODES	Annual (A-)	Spring/
		Summer (J-)
ID CODES		
B Spouse	<input type="checkbox"/> \$ 864.00	<input type="checkbox"/> \$ 512.00
C Each Child	<input type="checkbox"/> \$ 550.00	<input type="checkbox"/> \$ 326.00

INSURED CATEGORY: PART-TIME

F Spouse	<input type="checkbox"/> \$ 864.00	<input type="checkbox"/> \$ 512.00
G Each Child	<input type="checkbox"/> \$ 550.00	<input type="checkbox"/> \$ 326.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	<input type="checkbox"/> 08-19-2011 to 08-18-2012
Spring / Summer	<input type="checkbox"/> 01-19-2011 to 08-18-2012

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company authorized representative receives the application and correct premium payment.

Annual coverage expires 1 year following receipt of your premium or August 18, 2012, whichever is earlier.

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: \$22.00 x 3 months = \$66.00

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** name of authorized representative in US dollars. 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. The student is responsible for timely premium payments whether or not a premium notice is received.

To enroll online: If you would like to use a credit card to enroll, please go to www.uhcsr.com/delhi and select the Enroll Now link to enroll online.