UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR PART-TIME STUDENTS

COLLEGE OF SAINT ELIZABETH

PROCESSOR STAMP DATE RECEIVED HERE

2014-1665-61

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:	OR STUDENT ID #:	
LAST (FAMILY) NAME:	**FIRST (GIVEN) NAME:**	MIDDLE INITIAL:
GENDER: ❑ MALE ❑ 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:
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: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _____/_____/______ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _____/_____/______ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _____/_____/______ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: _____/_____/______ MONTH DAY YEAR
First (Given) Name	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: ____ (or of a parent if the student is under age 18) DATE: ____________________

COLLEGE OF SAINT ELIZABETH 2014-1665-61

CAMPUS LOCATION:

COLLEGE OF SAINT ELIZABETH

❑ **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: ❑ **Part-Time**

BASIC PLAN

PERIOD CODES	Annual (A-)	Spring / Summer (J-)
ID CODES		
2. Student	❑ $3,198.00	❑ $1,831.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-15-2014 to 08-14-2015
Spring / Summer	❑ 01-18-2015 to 08-14-2015

Payment Instructions: Make check or money order payable to First Risk Advisors in US dollars. Mail this enrollment card along with premium payment to:

First Risk Advisors
67 W Court Street
Doylestown, PA 18901

Your cancelled check is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.