PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR DEPENDENTS

WASHINGTON AND LEE UNIVERSITY

2015-1451-65

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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

STUDENT'S SIGNATURE: ____ DATE: ___________________________

CAMPUS LOCATION:

WASHINGTON AND LEE UNIVERSITY

❑ **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: ❑ **Domestic Undergraduate** ❑ **Domestic Graduate** ❑ **International**

PERIOD CODES		Annual (A-)	Spring / Summer (J-)
ID CODES			
2	Spouse	❑ $1,309.00	❑ $ 762.00
3	One Child	❑ $1,309.00	❑ $ 762.00
4	Two or More Children	❑ $2,618.00	❑ $1,524.00
5	Spouse + Two or More Children	❑ $3,927.00	❑ $2,286.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-15-2015 to 08-14-2016
Spring / Summer	❑ 01-15-2016 to 08-14-2016

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.