

**UNITEDHEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR PART-TIME / VOLUNTARY STUDENTS AND THEIR DEPENDENTS**

PROCESSOR STAMP DATE RECEIVED HERE

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**SETON HALL UNIVERSITY**

**2015-604-92**

**PRIMARY INSURED** Complete information below for Student.

SOCIAL SECURITY #:		OR STUDENT ID #:	
<b>LAST (FAMILY) NAME:</b>		<b>FIRST (GIVEN) NAME:</b>	
MIDDLE INITIAL:			
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH    DAY    YEAR	EXPECTED DATE OF GRADUATION: ____/____/____ MONTH    DAY    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).

<b>SPOUSE SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH    DAY    YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH    DAY    YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH    DAY    YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: ____/____/____ MONTH    DAY    YEAR
First (Given) Name		Middle Initial:	Last (Family) Name:
<b>CHILD SOCIAL SECURITY #:</b>		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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**CAMPUS LOCATION:**

SETON HALL 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:**  Part-Time

**PERIOD CODES**

Annual (A-)

Fall (F-)

**ID CODES**

- |                                  |                                     |                                     |
|----------------------------------|-------------------------------------|-------------------------------------|
| 1. Student                       | <input type="checkbox"/> \$1,580.00 | <input type="checkbox"/> \$ 790.00  |
| 2. Spouse                        | <input type="checkbox"/> \$1,580.00 | <input type="checkbox"/> \$ 790.00  |
| 3. One Child                     | <input type="checkbox"/> \$1,580.00 | <input type="checkbox"/> \$ 790.00  |
| 4. Two or More Children          | <input type="checkbox"/> \$3,160.00 | <input type="checkbox"/> \$1,580.00 |
| 5. Spouse + Two or More Children | <input type="checkbox"/> \$4,740.00 | <input type="checkbox"/> \$2,370.00 |

**PLEASE CHECK ALL APPROPRIATE BOXES**

**EFFECTIVE / EXPIRATION PERIODS:**

- |        |   |
|--------|---|
| Fall   | <input type="checkbox"/> 08-15-2015 to 01-13-2016 |
| Annual | <input type="checkbox"/> 08-15-2015 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.