

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR VOLUNTARY STUDENTS AND THEIR
DEPENDENTS
UNIVERSITY OF MARYLAND - COLLEGE PARK

2015-2071-91

PRIMARY INSURED Complete information below for Student.			
UNIVERSITY ID #:		SOCIAL SECURITY #:	
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:
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 or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: _____

DATE: _____

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF MARYLAND - COLLEGE PARK

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:

- GRADUATE**
- OTHER:**
Scholars, Exchange Students, Doctorates

EFFECTIVE / EXPIRATION PERIODS:

- Annual 08-01-2015 to 07-31-2016
- Fall 08-01-2015 to 12-31-2015
- Spring / Summer 01-01-2016 to 07-31-2016
- Summer 06-01-2016 to 07-31-2016

PERIOD CODES	Annual (A-)*	Fall (F-)	Spring/ *Summer (J-)	Summer (S-)
ID CODES				
1 Student	<input type="checkbox"/> \$1,509.00	<input type="checkbox"/> \$ 754.00	<input type="checkbox"/> \$ 755.00	<input type="checkbox"/> \$ 251.00
2 Student + Spouse	<input type="checkbox"/> \$3,018.00	<input type="checkbox"/> \$1,508.00	<input type="checkbox"/> \$1,510.00	<input type="checkbox"/> \$ 502.00
3 Student + One Child	<input type="checkbox"/> \$3,018.00	<input type="checkbox"/> \$1,508.00	<input type="checkbox"/> \$1,510.00	<input type="checkbox"/> \$ 502.00
4 Student + Two or More Children	<input type="checkbox"/> \$4,527.00	<input type="checkbox"/> \$2,262.00	<input type="checkbox"/> \$2,265.00	<input type="checkbox"/> \$ 753.00
5 Student + Spouse + One Child	<input type="checkbox"/> \$4,527.00	<input type="checkbox"/> \$2,262.00	<input type="checkbox"/> \$2,265.00	<input type="checkbox"/> \$ 753.00
6 Student + Spouse + Two or More Children	<input type="checkbox"/> \$6,036.00	<input type="checkbox"/> \$3,016.00	<input type="checkbox"/> \$3,020.00	<input type="checkbox"/> \$1,004.00

*The first payment is due upon receipt of application; Second payment is due on or before February 15, 2016

Payment Instructions: Make check or money order payable to First Risk Advisors 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:
 First Risk Advisors
 67 West 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.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____ Expiration Date _____
 Month _____ Year _____

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____