PROCESSOR STAMP DATE RECEIVED HERE

2015-2071-91

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS ONLY
UNIVERSITY OF MARYLAND - COLLEGE PARK

PRIMARY INSURED Complete information below for Student.

UNIVERSITY ID #:	SOCIAL SECURITY #:	
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 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: ________________________

UNIVERSITY OF MARYLAND - COLLEGE PARK 2015-2071-91

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:

❑ **UNDERGRADUATE**

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

PERIOD CODES		**Annual (A-)**	***Fall (F-)**	**Spring/ *Summer (J-)**
ID CODES				
2	Spouse	❑ $1,509.00	❑ $ 754.00	❑ $ 755.00
3	One Child	❑ $1,509.00	❑ $ 754.00	❑ $ 755.00
4	Two or More Children	❑ $3,018.00	❑ $1,508.00	❑ $1,510.00
5	Spouse + Two or More Children	❑ $4,527.00	❑ $2,262.00	❑ $2,265.00

*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 $_____._____