PROCESSOR STAMP DATE RECEIVED HERE

UNITEDHEALTHCARE INSURANCE COMPANY

ENROLLMENT FORM FOR DEPENDENTS ONLY

LA SALLE UNIVERSITY

2015-201198-61

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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

CAMPUS LOCATION:

LASALLE 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** ❑ **International Undergraduate**

❑ **Domestic Graduate** ❑ **International Graduate**

PERIOD CODES	Annual (A-)	Spring/Summer (J-)
ID CODES		
2. Spouse	❑ $1,476.00	❑ $ 871.00
3. One Child	❑ $1,476.00	❑ $ 871.00
4. Two or More Children	❑ $2,952.00	❑ $1,742.00
5. Spouse + Two or More Children	❑ $4,428.00	❑ $2,613.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-04-2015 to 08-03-2016
Spring/Summer	❑ 01-01-2016 to 08-03-2016

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.

The state of Pennslyvania requires [UnitedHealthcare Insurance Company] to request the following information about the Primary Insured. If you choose not to supply this information, please select the box below.

☐ I have read the request for information and choose not to supply a response

Race - Primary Insured's Racial background

W	**White Alone**
B	**Black Alone**
A	**Asian Alone**
I	**American Indian and Alaskan Native Alone**
P	**Native Hawaiian or Other Pacific Islander**
M	**Two or More Race Groups**
U	**Unknown**

Hispanic/Latino Origin or Descent

Hispanic/Latino origin refers to people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central or South America. Origins can be viewed as the ancestry, nationality lineage, or country in which the person or his/her ancestors were born before their arrival in the United States.		
☐	**1**	**Yes, the Primary Insured is of Hispanic origin or descent.**
☐	**2**	**No, the Primary Insured is not of Hispanic origin or descent.**