

PLEASE COMPLETE  
THIS FORM IN BLOCK  
LETTER PRINT USE  
BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY  
VOLUNTARY ENROLLMENT FORM FOR DEPENDENTS OF  
INTERNATIONAL STUDENTS  
UNIVERSITY OF SOUTH ALABAMA

PROCESSOR STAMP DATE RECEIVED HERE



2009-91-1

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ or SCHOOL ID# \_\_\_\_\_  
PRIMARY INSURED STUDENT NAME: \_\_\_\_\_

Last (Family) Name

First (Given) Name

Middle Initial

GENDER:  Male  Female DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ EXPECTED DATE OF GRADUATION: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Check one Month Day Year Month Year

PERMANENT ADDRESS: \_\_\_\_\_  
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route

City

County

State

ZIP Code

MAILING ADDRESS: \_\_\_\_\_  
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route

City

County

State

ZIP Code

TELEPHONE # \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

**Complete information below for Dependents to be insured. Dependent coverage is available only for Students insured under the Plan.**

SPOUSE: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number (Check One) Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number (Check One) Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number (Check One) Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number (Check One) Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Social Security Number (Check One) Month Day Year

First (Given) Name

M/I

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.**

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

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

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF SOUTH ALABAMA

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:**  INTERNATIONAL

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring (G-)	Spring/Summer (J-)	Summer (S-)
<u>ID CODES</u>					
B Spouse	<input type="checkbox"/> \$1,920.00	<input type="checkbox"/> \$ 805.00	<input type="checkbox"/> \$ 794.00	<input type="checkbox"/> \$ 1,115.00	<input type="checkbox"/> \$ 321.00
C Each Child	<input type="checkbox"/> \$1,233.00	<input type="checkbox"/> \$ 517.00	<input type="checkbox"/> \$ 510.00	<input type="checkbox"/> \$ 716.00	<input type="checkbox"/> \$ 206.00

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-01-2009 to 07-31-2010
Fall	<input type="checkbox"/> 08-01-2009 to 12-31-2009
Spring	<input type="checkbox"/> 01-01-2010 to 05-31-2010
Spring/Summer	<input type="checkbox"/> 01-01-2010 to 07-31-2010
Summer	<input type="checkbox"/> 06-01-2010 to 07-31-2010

**Payment Instructions:** Make check or money order payable to UnitedHealthcare StudentResources 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 UnitedHealthcare StudentResources, PO Box 809026, Dallas TX 75380-9026. **Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.**

**CHARGE CARD AUTHORIZATION PAYMENT INFORMATION**

CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month Year
AUTHORIZED SIGNATURE _____	DATE _____	
<b>OR</b> PAID BY CHECK # _____	AMOUNT PAID \$ _____	