PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

PROCESSOR STAMP DATE RECEIVED HERE

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR GRADUATE AND UNDERGRADUATE STUDENTS AND THEIR DEPENDENTS
YOUNGSTOWN STATE UNIVERSITY

2009-1119-78

SOCIAL SECURITY # ______- ______- _______ or SCHOOL ID# ____________________

PRIMARY INSURED STUDENT NAME: ________________________________
Last (Family) Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: _______ - _____ - _______ (Month Day Year) EXPECTED DATE OF GRADUATION: _______ - ______ (Month Year)

PERMANENT U.S. 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: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name ______ M/I ______ Last (Family) Name ______

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

First (Given) Name ______ M/I ______ Last (Family) Name ______

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

First (Given) Name ______ M/I ______ Last (Family) Name ______

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

First (Given) Name ______ M/I ______ Last (Family) Name ______

CHILD: ______-______-______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (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**.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

STUDENT'S SIGNATURE: ______________________________ DATE: ____________________

YOUNGSTOWN STATE UNIVERSITY 2009-1119-78

CAMPUS LOCATION:

❑ **ANY APPLICABLE CAMPUS**

CAMPUS/SCHOOL ATTENDING: Youngstown State University

Please Print Name of University Must be completed in order for application to be processed.

❑ **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 ❑ UNDERGRADUATE

PERIOD CODES / **ID CODES**		Annual (A-)	Fall (F-)	Spring/Summer (J-)	Summer (S-)
A	Student	❑ $ 988.00	❑ $ 450.00	❑ $ 558.00	❑ $ 204.00
B	Spouse	❑ $2,718.00	❑ $1,238.00	❑ $ 1,534.00	❑ $ 562.00
C	Each Child	❑ $1730.00	❑ $ 788.00	❑ $ 977.00	❑ $ 358.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-01-2009 to 07-31-2010
Fall	❑ 08-01-2009 to 01-10-2010
Spring / Summer	❑ 01-11-2010 to 07-31-2010
Summer	❑ 05-19-2010 to 07-31-2010

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective the date of receipt of this application and correct payment by the Insurance Company authorized representative.

Annual coverage expires 1 year following receipt of your premium or August 1, 2010, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. **Requested Effective Date:**________/________/________

Payment Instructions: Make check or money order payable to Student Insurance name of authorized representative 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 Student Insurance, 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 $________________ ❑**VISA or** ❑**MASTERCARD #**________________________________ **Expiration Date** ________-________ Month Year

AUTHORIZED SIGNATURE____ **DATE** ________________________

OR **PAID BY CHECK #** ________________ **AMOUNT PAID** $________________