

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR STUDENTS



MEREDITH COLLEGE

2008-933-1

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

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

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

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

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: MEREDITH COLLEGE

I elect to purchase Injury and Sickness insurance coverage under the College's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES

Insured Category All

PERIOD CODES

Basic (Injury and Sickness)

Annual (A-)

ID CODES

A Student  \$ 207.00

EFFECTIVE/EXPIRATION

Annual  08-10-2008 to 08-09-2009

**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 \$ \_\_\_\_\_  VISA or  MASTERCARD # \_\_\_\_\_ Expiration Date \_\_\_\_\_  
AUTHORIZED SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
**OR** PAID BY CHECK # \_\_\_\_\_ AMOUNT PAID \$ \_\_\_\_\_