

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS
COLLEGE OF WILLIAM AND MARY

PROCESSOR STAMP DATE RECEIVED HERE

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2011-1404-2

PRIMARY INSURED Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	EXPECTED DATE OF GRADUATION: _____/_____/_____	
	MONTH	DAY	YEAR
	MONTH	YEAR	
PERMANENT ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING 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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	
		MONTH	DAY
		YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	
		MONTH	DAY
		YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	
		MONTH	DAY
		YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____/_____/_____	
		MONTH	DAY
		YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> 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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly 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: _____

CAMPUS/SCHOOL ATTENDING: _____

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

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: DOMESTIC INTERNATIONAL

PERIOD CODES	Annual (A-)	Fall (F-)	Spring/ Summer (J-)	Summer (S-)
ID CODES				
A Student	<input type="checkbox"/> \$1,574.00	<input type="checkbox"/> \$ 724.00	<input type="checkbox"/> \$ 850.00	<input type="checkbox"/> \$ 280.00
B Spouse	<input type="checkbox"/> \$5,940.00	<input type="checkbox"/> \$2,734.00	<input type="checkbox"/> \$3,206.00	<input type="checkbox"/> \$1,058.00
C Each Child	<input type="checkbox"/> \$3,583.00	<input type="checkbox"/> \$1,649.00	<input type="checkbox"/> \$1,934.00	<input type="checkbox"/> \$ 638.00
D All Children	<input type="checkbox"/> \$4,776.00	<input type="checkbox"/> \$2,198.00	<input type="checkbox"/> \$2,578.00	<input type="checkbox"/> \$ 851.00

Optional coverages may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at the time of initial enrollment. The Named Insured may purchase optional coverages for himself or for himself and all Dependent family members.

\$125,000 OPTIONAL MAJOR MEDICAL

Annual (A-)

- E Opt Major Med/Student \$ 563.00
- F Opt Major Med/Spouse \$ 563.00
- G Opt Major Med/Each Child \$ 563.00

\$175,000 OPTIONAL MAJOR MEDICAL

Annual (A-)

- H Opt Major Med/Student \$ 680.00
- I Opt Major Med/Spouse \$ 680.00
- J Opt Major Med/Each Child \$ 680.00

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EFFECTIVE / EXPIRATION PERIODS:

- Annual 08-01-2011 to 07-31-2012
- Fall 08-01-2011 to 01-15-2012
- Spring / Summer 01-16-2012 to 07-31-2012
- Summer 05-28-2012 to 07-31-2012

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:
 UnitedHealthcare **Student**Resources
 PO Box 809026
 Dallas, TX 75380-9026.

Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

To enroll online: If you would like to use a credit card to enroll, please go to www.uhcsr.com/wm and select the Enroll Now link to enroll online.