

**UNITEDHEALTHCARE INSURANCE COMPANY
ELECTION FORM FOR INTERNATIONAL STUDENTS AND THEIR DEPENDENTS
METROPOLITAN STATE UNIVERSITY**

PROCESSOR STAMP DATE RECEIVED HERE

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2011-1768-4

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: _____ / _____ / _____ MONTH / DAY / YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH / YEAR	
PERMANENT U.S. 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. A student who requests to cancel coverage under the Policy will receive a refund of unearned premiums as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the insured within 30 days following the receipt of the insured's request for cancellation.

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: _____

CAMPUS LOCATION: METROPOLITAN STATE UNIVERSITY 2011-1786-4

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: International

PERIOD CODES	Annual (A-)	Fall (F-)	Spring/Summer (J-)	Summer (S-)
ID CODES				
A Student	<input type="checkbox"/> \$ 919.00	<input type="checkbox"/> \$ 350.00	<input type="checkbox"/> \$ 569.00	<input type="checkbox"/> \$ 267.00
B Spouse	<input type="checkbox"/> \$ 2752.00	<input type="checkbox"/> \$ 1048.00	<input type="checkbox"/> \$ 1074.00	<input type="checkbox"/> \$ 799.00
C Each Child	<input type="checkbox"/> \$ 1693.00	<input type="checkbox"/> \$ 645.00	<input type="checkbox"/> \$ 1048.00	<input type="checkbox"/> \$ 492.00

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

- Annual 08-15-2011 to 08-14-2012
- Fall 08-15-2011 to 12-31-2011
- Spring/Summer 01-01-2012 to 08-14-2012
- Summer 05-01-2011 to 08-14-2012

Payment Instructions: Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars. 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. 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 <https://www.uhcsr.com/minnesota> and select the Enroll Now link to enroll online.