

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR CONTINUATION STUDENTS AND THEIR
DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



UNIVERSITY OF TEXAS AT AUSTIN

2009-411-1

UT EID _____

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: _____

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ELIGIBILITY: All Insureds who have been continuously Insured under the school's regular student Policy for at least 6 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy are eligible to continue their coverage for a period of not more than 6 months under the school's Policy in effect.

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF TEXAS AT AUSTIN

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:

Continuation

PERIOD CODES	Monthly (MX)
ID CODES	
10 Student	<input type="checkbox"/> \$155.00
11 Spouse	<input type="checkbox"/> \$451.00
12 Each Child	<input type="checkbox"/> \$255.00

CONTINUATION OPTIONAL MAJOR MEDICAL	Monthly (MX)
14 Optional Major Medical/Student	<input type="checkbox"/> \$ 84.00
15 Optional Major Medical/Spouse	<input type="checkbox"/> \$ 84.00
16 Optional Major Medical/Each Child	<input type="checkbox"/> \$ 84.00

EFFECTIVE / EXPIRATION PERIODS:

Annual 08-25-2009 to 08-24-2010

<p>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.</p>	<p>CALCULATION FOR MONTHLY PREMIUM</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">MONTHLY RATE (ABOVE)</td> <td style="width: 30%; text-align: right;">\$ _____</td> </tr> <tr> <td>MULTIPLY BY # OF MONTHS TO PURCHASE</td> <td style="text-align: right;">X _____</td> </tr> <tr> <td>TOTAL PREMIUM ENCLOSED WITHOUT MAJOR MEDICAL</td> <td style="text-align: right;">\$ _____</td> </tr> </table>	MONTHLY RATE (ABOVE)	\$ _____	MULTIPLY BY # OF MONTHS TO PURCHASE	X _____	TOTAL PREMIUM ENCLOSED WITHOUT MAJOR MEDICAL	\$ _____
MONTHLY RATE (ABOVE)	\$ _____						
MULTIPLY BY # OF MONTHS TO PURCHASE	X _____						
TOTAL PREMIUM ENCLOSED WITHOUT MAJOR MEDICAL	\$ _____						

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

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