

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
DEPENDENT ENROLLMENT FORM FOR
UNIVERSITY OF DENVER

PROCESSOR STAMP DATE RECEIVED HERE



2009-5893-1

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

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.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

STUDENT'S SIGNATURE: _____ DATE: _____

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF DENVER

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: Quarter Dependents

| <u>PERIOD CODES</u> <u>ID CODES</u> | Fall (F-) | Fall 1 (F1) | Winter (W-) | Spring (G-) | Spring 1 (G1) | Summer (S-) |
|--|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| B Spouse | <input type="checkbox"/> \$2,842.00 | <input type="checkbox"/> \$1,421.00 | <input type="checkbox"/> \$1,421.00 | <input type="checkbox"/> \$2,842.00 | <input type="checkbox"/> \$1,421.00 | <input type="checkbox"/> \$1,421.00 |
| C Each Child | <input type="checkbox"/> \$1,683.00 | <input type="checkbox"/> \$ 842.00 | <input type="checkbox"/> \$ 842.00 | <input type="checkbox"/> \$1,683.00 | <input type="checkbox"/> \$ 842.00 | <input type="checkbox"/> \$ 842.00 |
| D All Children | <input type="checkbox"/> \$2,779.00 | <input type="checkbox"/> \$1,389.00 | <input type="checkbox"/> \$1,389.00 | <input type="checkbox"/> \$2,779.00 | <input type="checkbox"/> \$1,389.00 | <input type="checkbox"/> \$1,389.00 |

EFFECTIVE / EXPIRATION PERIODS:

| | |
|---------|---|
| Fall | <input type="checkbox"/> 09-01-2009 to 03-21-2010 |
| Fall 1 | <input type="checkbox"/> 09-01-2009 to 01-03-2010 |
| Winter | <input type="checkbox"/> 01-04-2010 to 03-21-2010 |
| Spring | <input type="checkbox"/> 03-22-2010 to 08-31-2010 |
| Spring1 | <input type="checkbox"/> 03-22-2010 to 06-13-2010 |
| Summer | <input type="checkbox"/> 06-14-2010 to 08-31-2010 |

INSURED CATEGORY: Semester Dependents

| <u>PERIOD CODES</u> <u>ID CODES</u> | Fall (F-) | Spring (G-) | Summer (S-) |
|--|-------------------------------------|-------------------------------------|-------------------------------------|
| F Spouse | <input type="checkbox"/> \$2,842.00 | <input type="checkbox"/> \$2,842.00 | <input type="checkbox"/> \$1,421.00 |
| G Each Child | <input type="checkbox"/> \$1,683.00 | <input type="checkbox"/> \$1,683.00 | <input type="checkbox"/> \$ 842.00 |
| H All Children | <input type="checkbox"/> \$2,779.00 | <input type="checkbox"/> \$2,779.00 | <input type="checkbox"/> \$1,389.00 |

EFFECTIVE / EXPIRATION PERIODS:

| | |
|--------|---|
| Fall | <input type="checkbox"/> 08-01-2009 to 12-31-2009 |
| Spring | <input type="checkbox"/> 01-01-2010 to 07-31-2010 |
| Summer | <input type="checkbox"/> 06-01-2010 to 07-31-2010 |

DEPENDENTS MAY ONLY ENROLL FOR THE CURRENT COVERAGE TERM. STUDENTS WISHING TO ENROLL THEIR DEPENDENTS FOR MORE THAN ONE TERM MUST COMPLETE A SEPARATE DEPENDENT ENROLLMENT FORM AT THE BEGINNING OF EACH COVERAGE TERM.

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources 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 **Student**Resources, 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 \$ _____ | <input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____ | Expiration Date ____ - ____ Month Year |
| AUTHORIZED SIGNATURE _____ | DATE _____ | |
| OR PAID BY CHECK # _____ | | AMOUNT PAID \$ _____ |