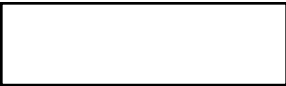


PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR
DEPENDENTS OF ATHLETES
MICHIGAN TECHNOLOGICAL UNIVERSITY

PROCESSOR STAMP DATE RECEIVED HERE



2009-126-8

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

MAILING ADDRESS: _____
House/Building Number and Street Name
_____ Apt. or P.O. Box # or Rural Route _____ City _____ County _____ State _____ ZIP Code _____

PERMANENT 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 certificate 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 certificate; 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: _____

MICHIGAN TECHNOLOGICAL UNIVERSITY

2009-126-8

CAMPUS/SCHOOL ATTENDING: _____ MICHIGAN TECHNOLOGICAL UNIVERSITY _____

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: <input type="checkbox"/> Dependents of Athletes				
PERIOD CODES	Annual (A-)	Fall (F-)	Spring (G-)	Summer (S-)
ID CODES				
B. Spouse/Domestic Partner	<input type="checkbox"/> \$ 1,474.00	<input type="checkbox"/> \$ 610.00	<input type="checkbox"/> \$ 490.00	<input type="checkbox"/> \$ 404.00
C. Each Child	<input type="checkbox"/> \$ 1,135.00	<input type="checkbox"/> \$ 469.00	<input type="checkbox"/> \$ 377.00	<input type="checkbox"/> \$ 311.00
D. All Children	<input type="checkbox"/> \$ 1,848.00	<input type="checkbox"/> \$ 764.00	<input type="checkbox"/> \$ 615.00	<input type="checkbox"/> \$ 506.00
Spring/Summer (J-)				
B. Spouse/Domestic Partner	<input type="checkbox"/> \$ 894.00			
C. Each Child	<input type="checkbox"/> \$ 688.00			
D. All Children	<input type="checkbox"/> \$ 1,121.00			
EFFECTIVE / EXPIRATION PERIODS:				
Annual	<input type="checkbox"/> 08-16-2009 to 08-15-2010			
Fall	<input type="checkbox"/> 08-16-2009 to 01-10-2010			
Spring	<input type="checkbox"/> 01-11-2010 to 05-09-2010			
Summer	<input type="checkbox"/> 05-10-2010 to 08-15-2010			
Spring/Summer	<input type="checkbox"/> 01-11-2010 to 08-15-2010			
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 to UnitedHealthcare Student Resources P.O. 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			Expiration Date
	<input type="checkbox"/> MASTERCARD # _____			____ - ____ Month Year
AUTHORIZED SIGNATURE _____			DATE _____	
OR PAID BY CHECK # _____		AMOUNT PAID \$ _____		