

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.

<b>PLEASE CHECK ALL APPROPRIATE BOXES</b>				
<b>INSURED CATEGORY:</b> <input type="checkbox"/> Dependents of Athletes				
<b>PERIOD CODES</b>	<b>Annual (A-)</b>	<b>Fall (F-)</b>	<b>Spring (G-)</b>	<b>Summer (S-)</b>
<b>ID CODES</b>				
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
<b>Spring/Summer (J-)</b>				
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			
<b>EFFECTIVE / EXPIRATION PERIODS:</b>				
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		
<b>Payment Instructions:</b> Make check or money order payable to UnitedHealthcare <b>StudentResources</b> in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card to UnitedHealthcare <b>StudentResources</b> 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.				
<b>CHARGE CARD AUTHORIZATION PAYMENT INFORMATION</b>				
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA			Expiration Date
	<input type="checkbox"/> MASTERCARD # _____			____ - ____ Month      Year
AUTHORIZED SIGNATURE _____			DATE _____	
<b>OR</b> PAID BY CHECK # _____	AMOUNT PAID \$ _____			