

Complete (please print) and return to the Student Insurance Office, room 201,
in the Administration Building by September 2. Fax 906-487-3220.

**UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR SUPPORTED GRADUATE STUDENTS**

MICHIGAN TECHNOLOGICAL UNIVERSITY

2009-126-1

MTU ID# _____

PRIMARY INSURED

STUDENT NAME: _____

Last (Family) Name

First (Given) Name

Middle Initial

MAILING ADDRESS: _____

House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route

City

State

Zip Code

TELEPHONE # _____ - _____ - _____ EMAIL ADDRESS: _____

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 in 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: _____



**GRADUATE STUDENT HEALTH INSURANCE
DEDUCTION AUTHORIZATION**

Soc. Sec. #

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Name: _____

PAYROLL DEDUCTION CODE:

G	S	H
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Bi-Weekly Amount:

		2	9	2	5
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Goal:

	2	3	4	0	0
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Start Date:

0	8	2	3	0	9
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I hereby authorize MTU to deduct the amount stated above from my pay and any balance due upon my termination from the University. There will be eight deductions during fall term for those students supported via assistantship. The full amount will be deducted from fellowship student's second check of the semester.

Employee Signature: _____

Date: _____

