

PLEASE COMPLETE THIS
FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



ROWAN UNIVERSITY

2008-201946-1

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

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 Injury & Sickness 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) I declare that I meet eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that I am not eligible, my Premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

FRAUD WARNING - Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: _____ DATE: _____
(or of parent if the student is under age 18)

ROWAN UNIVERSITY

2008-201946-1

CAMPUS/SCHOOL ATTENDING: ROWAN UNIVERSITY

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: Full-time (Matriculated) Part-time (Non-Matriculated)

PERIOD CODES

BASIC PLAN

<u>ID CODES</u>	Annual (A-)	Spring/Summer (J-)	Summer (S-)
A. Student	<input type="checkbox"/> \$ 158.00	<input type="checkbox"/> \$ 98.00	<input type="checkbox"/> \$ 40.00
B. Spouse	<input type="checkbox"/> \$ 660.00	<input type="checkbox"/> \$ 409.00	<input type="checkbox"/> \$ 166.00
C. Each Child	<input type="checkbox"/> \$ 396.00	<input type="checkbox"/> \$ 245.00	<input type="checkbox"/> \$ 100.00

Effective / Expiration:

Annual 08-15-2008 to 08-01-2009
Spring/Summer 01-01-2009 to 08-01-2009
Summer 05-01-2009 to 08-01-2009

Payment Instructions: Make check or money order payable to United Healthcare StudentResources in US dollars or refer to the ChargeCard Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to:

First Risk Advisors
10 S. Clinton Street, Suite 10
Doylestown, PA 18901

Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____ Expiration Date _____
Month Year

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____