

UnitedHealthcare
Student Resources

Name: _____
 ID Number: _____
 Group Name: University of Illinois Springfield
 Policy #: 2009-2390-5
 Customer Service: 1-800-767-0700

07-ID2 Underwritten by United HealthCare Ins. Co.

**University of Illinois Springfield
 CONVERSION STUDENT INSURANCE ENROLLMENT CARD
 (PLEASE PRINT)**

**UNITED HEALTHCARE INSURANCE COMPANY
 2009-2390-5**

Student's Name _____ / _____ / _____
 Male Female Last First MI

Permanent US Address _____
 Street or PO Box City State Zip

Social Security # _____ Date of Birth _____ Phone # (____) _____

Expected Graduation Date: Month _____ Date _____ E-Mail address _____

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under the Plan and cannot exceed coverage purchased by the student.

	Last Name	First Name	MI	Date of Birth	Social Security #
Spouse:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____

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. It is the student's responsibility for timely renewal payments. By signing below, 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; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.

Signature of Student _____ **Date** _____

PLEASE CHECK ALL APPROPRIATE BOXES:

2009-2390-5

ELIGIBILITY REQUIREMENT: All Insured Persons who have been continuously insured for at least 3 consecutive months under the school's blanket student insurance plan whose coverage has terminated because of loss of eligibility are eligible to enroll in this plan in accordance with the provisions of the Conversion Privilege endorsement.

Application and full premium must be received within 14 days after your expiration date under the blanket student plan from which conversion is allowed. Coverage will be effective the date the student plan expires as stated in the Master Policy on file at the Company. If you do not enroll within 14 days, you are no longer eligible for coverage.

Check the Appropriate Box(es) Monthly (MX)

- | | |
|----------------------------|-----------------------------------|
| DOMESTIC CONVERSION | |
| 1. Student | <input type="checkbox"/> \$209.00 |
| 2. Spouse | <input type="checkbox"/> \$578.00 |
| 3. All Children | <input type="checkbox"/> \$346.00 |

Payment Instructions: Make check or money order payable to 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 United Healthcare **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 payment whether or not a renewal notice is received**

CALCULATION FOR MONTHLY PREMIUM	
MONTHLY RATE (ABOVE)	\$ _____
MULTIPLY BY # OF MONTHS TO PURCHASE	X _____
TOTAL PREMIUM ENCLOSED	\$ _____
PAYMENT INFORMATION	
CHARGE FULL AMOUNT \$ _____	EXP DATE _____ / _____
<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD	
Card# _____	
SIGNATURE OF CARDHOLDER _____	
OR PAID BY CHECK # _____	
AMOUNT PAID \$ _____	

CLAIM INSTRUCTIONS

Claims should be submitted to the company within 90 days after date of treatment. Please mail all medical and hospital bills along with the insured student's name and patient's name, ID number, address, and the name of the college or university under which the student is insured to the address listed on this card.

NOTICE TO ALL HEALTHCARE PROVIDERS

This card is not a guarantee of coverage. For information concerning coverage, co-payment and claims instructions, please call Customer Service at the number listed on the front of this card.

www.uhcsr.com