

PLEASE COMPLETE THIS FORM  
IN BLOCK LETTER PRINT  
USE BLACK INK

PROCESSOR STAMP DATE RECEIVED HERE



UNITED HEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR DEPENDENTS ONLY

UNIVERSITY OF ILLINOIS  
SPRINGFIELD

2009-2390-1

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 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) He/She meets the eligibility requirements for this coverage as described in the brochure; 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.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# UNIVERSITY OF ILLINOIS SPRINGFIELD

2009-2390-1

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:**  Domestic Graduate  International Graduate  
 Domestic UnderGraduate  International UnderGraduate

**Period Codes:** Annual (A-) Fall (F-) Spring (G-) Summer (S-)

**ID Codes:**

B Spouse	<input type="checkbox"/> \$1,739.00	<input type="checkbox"/> \$685.00	<input type="checkbox"/> \$685.00	<input type="checkbox"/> \$369.00
C All Children	<input type="checkbox"/> \$1,042.00	<input type="checkbox"/> \$410.00	<input type="checkbox"/> \$410.00	<input type="checkbox"/> \$222.00

### EFFECTIVE / EXPIRATION PERIODS:

Annual  08-16-2009 to 08-15-2010  
Fall  08-16-2009 to 01-09-2010  
Spring  01-10-2010 to 05-31-2010  
Summer  06-01-2010 to 08-15-2010

**Payment Instructions:** Make check or money order payable to UnitedHealthcare StudentResources 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 UnitedHealthcare StudentResources, 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 payments whether or not a renewal notice is received.

### CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

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

AUTHORIZED SIGNATURE \_\_\_\_\_

**OR** PAID BY CHECK # \_\_\_\_\_ AMOUNT PAID \$ \_\_\_\_\_