

**UNITEDHEALTHCARE INSURANCE COMPANY**  
**ENROLLMENT FORM FOR DEPENDENTS**  
**UNIVERSITY OF ILLINOIS SPRINGFIELD**

PROCESSOR STAMP DATE RECEIVED HERE

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**2011-2390-1**

<b>PRIMARY INSURED</b> Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH / YEAR	
PERMANENT ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:
TELEPHONE #:		EMAIL ADDRESS:	

**DEPENDENT INFORMATION:** Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	
First (Given) Name	Middle Initial:	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.

**NOTICE:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

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

DATE: \_\_\_\_\_

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

<b>PERIOD CODES</b>	Annual (A-)	Fall (F-)	Spring (G-)	Summer (S-)
<b>ID CODES</b>				
B Spouse	<input type="checkbox"/> \$ 1,954.00	<input type="checkbox"/> \$ 774.00	<input type="checkbox"/> \$ 773.00	<input type="checkbox"/> \$ 406.00
C All Children	<input type="checkbox"/> \$ 1,171.00	<input type="checkbox"/> \$ 464.00	<input type="checkbox"/> \$ 464.00	<input type="checkbox"/> \$ 243.00

**PLEASE CHECK ALL APPROPRIATE BOXES**

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-16-2011 to 08-15-2012
Fall	<input type="checkbox"/> 08-16-2011 to 01-09-2012
Spring	<input type="checkbox"/> 01-10-2012 to 05-31-2012
Summer	<input type="checkbox"/> 06-01-2012 to 08-15-2012

**EFFECTIVE AND TERMINATION DATES:**

**Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.**  
 Annual coverage expires 1 year following receipt of your premium or August 15, 2012 , whichever is earlier.

**Please Note:** If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. **Requested Effective Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **StudentResources** in US dollars . 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. The student is responsible for timely premium payments whether or not a premium notice is received.

**To enroll online:** If you would like to use a credit card to enroll, please go to [www.uhcsr.com](http://www.uhcsr.com) , and use the Find My School's Plan link to search for your school. Select your school name from the search results to go to your school's page, and then select the Enroll Now link to enroll online.