

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DOMESTIC STUDENTS
AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



SEATTLE PACIFIC UNIVERSITY

2007-1462-1

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.**

STUDENT'S SIGNATURE: _____ DATE: _____

SEATTLE PACIFIC UNIVERSITY

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CAMPUS/SCHOOL ATTENDING: SEATTLE PACIFIC UNIVERSITY

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: All

PERIOD CODES

	Annual (A-)	Fall (F-)	Winter (W-)	Spring/ Summer (J-)
ID Codes:				
A. Student	<input type="checkbox"/> \$ 974.00	<input type="checkbox"/> \$ 272.00	<input type="checkbox"/> \$ 223.00	<input type="checkbox"/> \$ 493.00
B. Spouse	<input type="checkbox"/> \$3,034.00	<input type="checkbox"/> \$ 848.00	<input type="checkbox"/> \$ 695.00	<input type="checkbox"/> \$1,535.00
C. Each Child	<input type="checkbox"/> \$1,217.00	<input type="checkbox"/> \$ 340.00	<input type="checkbox"/> \$ 279.00	<input type="checkbox"/> \$ 616.00

Periods:

Annual	<input type="checkbox"/> 09-24-2007 to 09-23-2008
Fall	<input type="checkbox"/> 09-24-2007 to 01-02-2008
Spring	<input type="checkbox"/> 01-03-2008 to 03-25-2008
Summer	<input type="checkbox"/> 03-26-2008 to 09-23-2008

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 \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date _____ - _____ Month Year
AUTHORIZED SIGNATURE _____	DATE _____	
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____		