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

2008-1462-1

SOCIAL SECURITY # _______-_____-___________ **or** SCHOOL ID# ____________________

PRIMARY INSURED
STUDENT NAME: ____
Last (Family) Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: ______ - ____ - ______ (Month Day Year) EXPECTED DATE OF GRADUATION: ______ - _____ (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: ______ - ______ - ______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______ - ______ - ______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______ - ______ - ______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______ - ______ - ______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______ - ______ - ______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______ - ______ - ______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______ - ______ - ______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______ - ______ - ______ (Month Day Year)

____
First (Given) Name M/I Last (Family) Name

CHILD: ______ - ______ - ______ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______ - ______ - ______ (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: ____________________

06–NRL

SEATTLE PACIFIC UNIVERSITY

2008-1462-1

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	❑ $ 937.00	❑ $ 270.00	❑ $ 220.00	❑ $ 466.00
B. Spouse	❑ $2,919.00	❑ $ 840.00	❑ $ 685.00	❑ $1,452.00
C. Each Child	❑ $1,171.00	❑ $ 337.00	❑ $ 275.00	❑ $ 582.00

EFFECTIVE/TERMINATION DATES

Annual	❑ 09-24-2008 to 09-23-2009
Fall	❑ 09-24-2008 to 01-02-2009
Spring	❑ 01-05-2009 to 03-29-2009
Summer	❑ 03-30-2009 to 09-23-2009

Payment Instructions: Make check or money order payable to UnitedHealthcare **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 UnitedHealthcare **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 payments 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 $ ____________ .