UNIVERSITY OF MIAMI

2010-11 DEPENDENTS OF GRADUATE STUDENTS ENROLLMENT FORM

UNITED HEALTHCARE INSURANCE COMPANY Policy #709872

PLEASE PRINT CLEARLY – FAILURE TO PROVIDE ALL INFORMATION MAY DELAY OR VOID YOUR INSURANCE

STUDENT Last Name:

First Name: Middle Initial:

School I.D. # OR Social Security # - -

Date of Birth (Month/day/year) [ ] Male [ ] Female

Mailing Address:

City: State: Zip Home Country

Phone # ( ) EMAIL ADDRESS:

SELECT STUDENT CATAGORY: [ ] DOMESTIC GRADUATE [ ] INTERNATIONAL GRADUATE

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan. Coverage must be purchased at the time of primary insured's enrollment or within 30 days of birth/marriage or arrival in country

Spouse Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 1 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 2 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

CHILD 3 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

DEPENDENT PREMIUM RATES

	ANNUAL (A) 08/15/2010-8/14/2011	FALL ONLY (F) 8/15/2010-1/09/2011	SPRING/SUMMER(J) 1/10/2011-8/14/2011	SUMMER (S) 5/10/2011-8/14/2011
Spouse				
Under age 25	☐$4,878.00	☐$2,040.00	☐$2,843.00	☐$1,224.00
Ages 25-34	☐$5,948.00	☐$2,486.00	☐$3,466.00	☐$1,492.00
Ages 35-44	☐$7,591.00	☐$3,172.00	☐$4,424.00	☐$1,903.00
Ages 45 & over	☐$9,730.00	☐$4,064.00	☐$5,670.00	☐$2,438.00
Each Child	☐$2,002.00	☐$ 840.00	☐$1,167.00	☐$ 505.00

Premium Calculation

Spouse **$**_____

Each Child _____ **x** **$**_____ **= $**_____

 # Children x premium

Premium now due **$**_____

METHOD OF PAYMENT

[ ] CHECK [ ] MONEY ORDER Make payable to University of Miami [ ] Credit Card (complete below)

Credit Card Authorization – [ ] MasterCard [ ] Visa Please bill my card for my insurance premium shown above

Cardholder Name (Last/First) _____

Cardholder Number: / / / / / / / / / / / / / / / Expiration Date (mo/year) _____ I _____.

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. Policy renewal is the responsibility of the student / dependent and must be requested prior to the termination of the current policy to prevent a lapse in coverage. **PREMIUM WILL NOT BE REFUNDED EXCEPT FOR INELIGIBILITY OR ENTRANCE INTO THE ARMED FORCES**.

Student's Signature Date

FOR QUESTIONS PLEASE CONTACT:

STUDENT HEALTH SERVICE 5513 MERRICK DRIVE CORAL GABLES FL 33146

PHONE 305-284-1652 FAX 305-284-4905

APPLICATIONS CAN BE MAILED TO ADDRESS ABOVE OR IF PAYING BY CREDIT CARD CAN BE FAXED TO 305-284-4905

Do not assume insurance is effective until credit card has been charged, or receipt of check has been acknowledged.