

UNIVERSITY OF MIAMI

2010-11 DEPENDENTS OF UNDERGRADUATE 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 UNDERGRADUATE [] INTERNATIONAL UNDERGRADUATE

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	<input type="checkbox"/> \$3,800.00	<input type="checkbox"/> \$1,590.00	<input type="checkbox"/> \$2,215.00	<input type="checkbox"/> \$ 955.00
Ages 25-34	<input type="checkbox"/> \$4,648.00	<input type="checkbox"/> \$1,944.00	<input type="checkbox"/> \$2,709.00	<input type="checkbox"/> \$1,167.00
Ages 35-44	<input type="checkbox"/> \$5,897.00	<input type="checkbox"/> \$2,465.00	<input type="checkbox"/> \$3,437.00	<input type="checkbox"/> \$1,479.00
Ages 45 & over	<input type="checkbox"/> \$7,577.00	<input type="checkbox"/> \$3,166.00	<input type="checkbox"/> \$4,416.00	<input type="checkbox"/> \$1,899.00
Each Child	<input type="checkbox"/> \$1,629.00	<input type="checkbox"/> \$ 684.00	<input type="checkbox"/> \$ 950.00	<input type="checkbox"/> \$ 411.00

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) ____ ____ .

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.