UNIVERSITY OF MIAMI
2010-2011 VISITING SCHOLAR ENROLLMENT FORM
UNITED HEALTHCARE INSURANCE COMPANY Policy #709872

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

SCHOLAR Last Name:

First Name: Middle Initial:

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

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

Mailing Address:

City: State: Zip Home Country

Phone # ( ) EMAIL ADDRESS:

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

QUARTERLTY PREMIUM RATES –
FOR COVERAGE EFFECTIVE 8/15/2010 OR AFTER – COVERAGE CANNOT EXTEND BEYOND 8/14/2011

	Quarterly Rate
Scholar	☐$ 567.00
Spouse	
Under age 25	☐$1,228.00
Ages 25-34	☐$1,492.00
Ages 35-44	☐$1,907.00
Ages 45 & over	☐$2,441.00
Each Child	☐$ 509.00

EFFECTIVE DATE OF COVERAGE _____
[EARLIEST EFFECTIVE DATE 8/15/2010– ALL COVERAGE TERMINATES ON 8/14/2011]
Number of quarters coverage needed _____

PREMIUM CALCULATION
SCHOLAR $_____
SPOUSE $_____
EACH CHILD $_____

PREMIUM NOW DUE $_____

METHOD OF PAYMENT

[ ] CHECK [ ] MONEY ORDER Make payable to Student Insurance [ ] 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/SCHOLAR: 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**.

SCHOLAR'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.

IF RECEIPT IS NEEDED BY YOUR DEPARTMENT PLEASE PUT FAX NUMBER AND CONTACT NAME TO FAX TO

CONTACT NAME: **FAX NUMBER:**