FLORIDA ATLANTIC UNIVERSITY

2009-2010 UNITED HEALTHCARE ENROLLMENT FORM 2009-34-1

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

STUDENT/SCHOLAR Last Name: HOME COUNTRY:

First Name: Middle Initial:

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

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

Mailing Address:

City: State: Zip

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.

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

PREMIUM PLEASE CHECK APPROPRIATE BOX

**Optional Intercollegiate Sports coverage may only be purchased simultaneously and in conjunction with the purchase of Basic coverage at time of initial enrollment in this plan

Domestic Student

☐ **GRADUATE** ☐**UNDERGRADUATE**

	Annual	Fall	Spring	Spring/Summer	Summer
Student	☐$1,222.00	☐$ 485.00	☐$ 430.00	☐$ 762.00	☐$ 331.00
Spouse	☐$2,972.00	☐$1,179.00	☐$ 1,046.00	☐$ 1,852.00	☐$ 806.00
Each Child	☐$1,879.00	☐$ 746.00	☐$ 662.00	☐$ 1,171.00	☐$ 509.00
All Child(ren)	☐$3,760.00	☐$1,492.00	☐$ 1,324.00	☐$ 2,343.00	☐$1,019.00
**Opt Sports/student	☐$ 500.00				

EFFECTIVE/EXPIRATION PERIODS

☐**ANNUAL** 8/17/2009 TO 8/16/2010 ☐**SPRING/SUMMER** 1/6/2010 TO 8/16/2010 ☐ **SUMMER** 5/12/2010 TO 8/16/2010

☐**FALL** 8/17/2009 TO 1/5/2010 ☐ **SPRING** 1/6/2010 TO 5/11/2010

TOTAL PREMIUM DUE $_____

METHOD OF PAYMENT[ ] CHECK [ ] MONEY ORDER Make payable to Student Insurance [ ] Credit Card (complete below)

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

Cardholder Name (Last/First)_____

Cardholder Number: I I I I I I I I I I I I I I I I 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. **PREMIUM WILL NOT BE REFUNDED EXCEPT FOR ENTRANCE INTO THE ARMED FORCES**.

I understand that I must be student/scholar at FAU to purchase this insurance

Student's Signature Date

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS, INC. 600 CORPORATE DRIVE #101 FORT LAUDERDALE FL 33334

PHONE 800-356-1235 * 954-771-5883 FAX 954-772-0872

APPLICATIONS CAN BE MAILED TO ADDRESS ABOVE OR IF PAYING BY CREDIT CARD CAN BE FAXED TO 954-772-0872