FLORIDA ATLANTIC UNIVERSITY

2008-09 UNITED HEALTHCARE ENROLLMENT FORM 2008-34-1

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

☐ **International Student**

☐ **GRADUATE** ☐**UNDERGRADUATE**

	Annual 8/17/2008 – 8/16/2009	**Spring/Summer** 1/2/2009 to 8/16/2009	**Summer** 5/8/2009 to 8/16/2009
Student	☐$1,182.00	☐$ 750.00	☐$ 334.00
Spouse	☐$2,888.00	☐$1,832.00	☐$ 815.00
Each Child	☐$1,826.00	☐$1,158.00	☐$ 515.00
All Child(ren)	☐$3,653.00	☐$2,317.00	☐$1,031.00
**Opt Sports/student	☐$ 485.00		

☐ **Visiting Scholar**

	Annual Rates 8/17/2008 to 8/16/2009	**Monthly (cannot be purchased after 7/16/2009)**	**Requested Effective Date for Monthly** _____
Scholar	☐$1,182.00	☐**$** 100.00	_____ x _____ no. of months = $_____
Spouse	☐**$**2,888.00	☐**$** 245.00	_____ x _____ no. of months = $_____
Each Child	☐$1,826.00	☐**$** 155.00	_____ x _____ no. of months = $_____
All Child(ren)	☐$3,653.00	☐$ 311.00	_____ x _____ no. of months = $_____

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: | | | | | | | | | | | | | | | | 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. **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