

**IMPORTANT: Coverage will not begin until payment is received and processed.**  
Send completed application with check made payable to UnitedHealthcare **StudentResources** to:  
UnitedHealthcare **StudentResources**, PO Box # 809026, Dallas, Texas 75380-9026.

SOCIAL SECURITY NUMBER		SCHOOL ID NUMBER		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change Date of Change ____/____/____	
LAST NAME		FIRST NAME		MI	ENROLLEE'S DATE OF BIRTH
ADDRESS			CITY	STATE	ZIP
TELEPHONE NUMBER    Home (    )    Work (    )				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Married	
PLAN PERIOD <input type="checkbox"/> Annual    Enrollment Deadline: 10/15/2009 <input type="checkbox"/> Semi Annual <sup>1</sup> Enrollment Deadline: 10/15/2009 <input type="checkbox"/> Semi Annual <sup>2</sup> Enrollment Deadline: 04/14/2010					
PLAN COVERAGE <input type="checkbox"/> Student <input type="checkbox"/> Student + Spouse (or Domestic Partner*) <input type="checkbox"/> Student + Child(ren) <input type="checkbox"/> Student + Family					

<b>INFORMATION FOR DEPENDENT COVERAGE</b> <b>Spouse &amp; Unmarried Dependent Children Only (Include Date of Birth)</b>						
First Name	Initial	Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school	
				<input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Domestic Partner*	<input type="checkbox"/> Student at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Change <input type="checkbox"/> F    _____ Carrier Name <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Change <input type="checkbox"/> F    _____ Carrier Name <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Change <input type="checkbox"/> F    _____ Carrier Name <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Change <input type="checkbox"/> F    _____ Carrier Name <input type="checkbox"/> Cancel
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter	<input type="checkbox"/> Student at _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> M <input type="checkbox"/> Other Dental Insurance <input type="checkbox"/> Change <input type="checkbox"/> F    _____ Carrier Name <input type="checkbox"/> Cancel

\* Domestic Partner coverage is determined by your Student Health Plan. Please confirm coverage for Domestic Partners with your medical carrier.  
 \*\* For court ordered dependent, legal documentation must be attached. Please see school representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible subscriber, please provide address on separate sheet.

<b>Annual</b>	Student -	\$364.44	Student + Child(ren) -	\$953.16	Student + Spouse -	\$728.76	Student + Family -	\$1,373.64
<b>Semi Annual<sup>1</sup></b>	Student -	\$182.22	Student + Child(ren) -	\$476.58	Student + Spouse -	\$364.38	Student + Family -	\$686.82
<b>Semi Annual<sup>2</sup></b>	Student -	\$182.22	Student + Child(ren) -	\$476.58	Student + Spouse -	\$364.38	Student + Family -	\$686.82

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION				Expiration Date
Charge Full Amount \$	_____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD #	_____	____ - ____ Month    Year
Authorized Signature	_____	Date	_____	
<b>OR</b> Paid by Check #		_____	Amount Paid \$	_____

I confirm that the information I have provided on this form is complete and accurate.  
 I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.  
 I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.  
 I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.  
 Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**The Certificate provides dental benefits only. Review your Certificate carefully.**  
 SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_