

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

PROCESSOR STAMP DATE RECEIVED HERE

UNITED HEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR DEPENDENTS

OHIO UNIVERSITY

2008-1103-1

SOCIAL SECURITY # _____ and SCHOOL ID# _____
PRIMARY INSURED _____
STUDENT NAME: _____
Last Name _____

GENDER: Male Female DATE OF BIRTH: _____ EXPECTED DATE OF GRADUATION: _____
Check one Month Day Year Month Year

PERMANENT ADDRESS: _____
House/Building Number and Street Name _____

Apt. or P.O. Box # or Rural Route City County State ZIP Code

MAILING ADDRESS: _____
House/Building Number and Street Name _____

Apt. or P.O. Box # or Rural Route City County State ZIP Code

TELEPHONE # _____ E-MAIL ADDRESS: _____

Complete information below for Dependents to be insured. Dependent coverage is available only for Dependents of Students insured under the Plan.

SPOUSE: _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

DOMESTIC PARTNER: _____
First (Given) Name _____ MI _____ Last (Family) Name _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

First (Given) Name MI _____ Last (Family) Name _____

* A completed Affidavit of Domestic Partnership must be submitted with this Dependent Enrollment Form if Domestic Partner coverage is requested.

CHILD: _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ MI _____ Last (Family) Name _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ MI _____ Last (Family) Name _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ MI _____ Last (Family) Name _____
Social Security Number _____
 Male Female Date of Birth: _____
(Check One) Month Day Year

First (Given) Name MI _____ Last (Family) Name _____

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 ineligibility or entrance into the armed forces.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

STUDENT'S SIGNATURE: _____ DATE: _____

