PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

OHIO UNIVERSITY

2008-1103-1

SOCIAL SECURITY # _____-_____-________ **and** SCHOOL ID# ________________

PRIMARY INSURED STUDENT NAME: ______________________________
Last Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: _____ - _____ - _____ (Month Day Year) EXPECTED DATE OF GRADUATION: _____ - _____ (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 (Check One) Date of Birth: _____ - _____ - _____ (Month Day Year)

____
First (Given) Name | M/I | Last (Family) Name

DOMESTIC PARTNER: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: _____ - _____ - _____ (Month Day Year)

____
First (Given) Name | M/I | 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 (Check One) Date of Birth: _____ - _____ - _____ (Month Day Year)

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | 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: ________________

06-NRL

UNITED HEALTCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS
OF INTERNATIONAL STUDENTS

The following information must be provided before insurance coverage can begin:

University PID# : ________________ **Social Security# :** __________________ **Gender: Male** ____ **Female** ____

Date of Birth: _______________ **University E-mail:** _____________________ **Telephone# :** _______________

Student's Name: ____

Local Address: ____
Street Apt# City State Zip

International Student Dependent Insurance Rates:

ID Codes	Fall(F-)	Winter(W-)	Spring 1 (G2)	Spring 2 (G2)	Summer (S-)	1st Special (E1)
B. Spouse Domestic Partner	☐ $713.00 ISDI	☐ $713.00 ISDI	☐ $713.00 ISDI	☐ $909.00 ISDS	☐ $416.00 ISDU	☐ $199.00 ISDA
C. All Children	☐ $409.00 IACI	☐ $409.00 IACI	☐ $409.00 IACI	☐ $521.00 IACS	☐ $238.00 IACU	☐ $114.00 IACA

EFFECTIVE / EXPIRATION DATES

Fall Quarter	☐09/01/08 - 12/31/08
Winter Quarter	☐01/01/09 - 04/30/09
Spring 1 Quarter	☐05/01/09 - 08/31/09
Spring 2 Quarter (New)	☐03/30/09 - 08/31/09
Summer Quarter (New)	☐06/22/09 - 08/31/09

OHIO UNIVERSITY OFFICE OF THE BURSAR

IMPORTANT! This form will be submitted to the Bursar's Office and the charge for the dependent insurance plan will be put on your student account. This is in addition to the charge for the student insurance. ***This enrollment form must be completed each quarter.***

By signing this form you are agreeing to allow the Bursar's Office to put the premium indicated above on your student account.

_________________________________ Student Signature

_______________ Date

Mail this form and payment to: Ohio University, Office of the Cashier, Chubb Hall, Athens, OH 45701-2979. Or present payment to the Student Health Insurance Office at Hudson Health Center, Room 233. Coverage becomes effective on the start date of the Coverage Period if the form is received in the Bursar's office or the Student Insurance Office prior to the Enrollment deadlines (Fall 10/13/08; Winter 02/09/09 Spring 05/04/09; Summer 07/13/09). No enrollments will be accepted after these dates.

Online Services: Please visit our website www.uhcsr.com/college/viewbrochures.aspx to view and print brochures and enrollment cards (printable using Adobe Acrobat), and to view participating provider lists.