

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR OPTIONAL MAJOR MEDICAL

PROCESSOR STAMP DATE RECEIVED HERE



OHIO UNIVERSITY

2009-1103-1

SOCIAL SECURITY # _____ - _____ - _____ or SCHOOL ID# _____

PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name

_____ First (Given) Name Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ EXPECTED DEPARTURE DATE: _____ - _____ Year
Check one Month Day Year (Completion of Academic Program) 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 Students insured under the Plan.

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

_____ First (Given) Name M/I Last (Family) Name

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

_____ First (Given) Name M/I Last (Family) Name

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

_____ First (Given) Name M/I Last (Family) Name

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

_____ First (Given) Name M/I Last (Family) Name

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

OHIO UNIVERSITY

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CAMPUS/SCHOOL ATTENDING: _____ OHIO UNIVERSITY _____

I elect to purchase Injury and Sickness insurance coverage under the school's student insurance plan. Below are the choices I have made.

OPTIONAL MAJOR MEDICAL MAY ONLY BE PURCHASED AT THE TIME OF INITIAL ENROLLMENT IN THE PLAN AND MAY NOT BE ADDED LATER.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: Domestic Special: J-1 Scholars
 International English Language Program

Optional Major Medical

PERIOD CODES: Annual (A-)

ID Codes:

D. Student \$ 600.00
E. Spouse \$ 600.00
F. Each Child \$ 600.00

EFFECTIVE / EXPIRATION PERIODS:

Annual 09-01-2009 to 08-31-2010

Payment Instructions: Make check or money order payable to Wells Fargo Insurance Services in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to Wells Fargo Insurance Services, P.O.Box 276, Columbus, OH 43216-0276. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____ Expiration Date _____
Month - Year
Three Digit Authorization Code _____ (on back of card)
AUTHORIZED SIGNATURE _____ DATE _____
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____