

**PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK**

**UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR J-1 SCHOLARS AND
ENGLISH LANGUAGE PROGRAM
STUDENTS AND THEIR DEPENDENTS**



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 Other 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 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: _____

CAMPUS/SCHOOL ATTENDING: OHIO UNIVERSITY

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:

Special: J-1 Scholars English Language Program

PERIOD CODES

Monthly (MX)

Weekly (LX)

ID CODES

A Student	<input type="checkbox"/> \$ 92.00	<input type="checkbox"/> \$ 22.00
B Spouse	<input type="checkbox"/> \$ 194.00	<input type="checkbox"/> \$ 45.00
C All Children	<input type="checkbox"/> \$ 112.00	<input type="checkbox"/> \$ 26.00

**PLEASE NOTE: DEPENDENTS MAY NOT COVERED UNDER THIS PLAN
UNLESS THE STUDENT IS COVERED UNDER THIS PLAN.**

EFFECTIVE AND EXPIRATION DATES:

Coverage will become effective the date of receipt of this application and correct payment by the Insurance Company.

Monthly coverage expires 1 month following receipt of your premium or August 31, 2010, whichever is earlier.
Weekly coverage expires 1 week following receipt of your premium or August 31, 2010, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. **Requested Effective Date:** _____ / _____ / _____

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.

To Calculate Your Rate:

Rate x # of months eligible + Rate x # of weeks eligible = Amount Due
Example: \$92.00 x 2 months + \$22.00 x 2 weeks = \$228.00

CALCULATION FOR TOTAL PREMIUM

1. MONTHLY RATE (ABOVE)	\$	_____
2. MULTIPLY BY # OF MONTHS TO PURCHASE	X	_____
3. WEEKLY RATE (ABOVE)	\$	_____
4. MULTIPLY BY # OF WEEKS TO PURCHASE	X	_____
5. ADD LINES 2 AND 4. SUM EQUALS TOTAL PREMIUM ENCLOSED	\$	_____

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____ Expiration Date _____ / _____ / _____
Three Digit Authorization Code _____ (on back of card)

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____