

PLEASE COMPLETE THIS FORM  
IN BLOCK LETTER PRINT  
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY  
ENROLLMENT FORM FOR UNDERGRADUATE STUDENTS, ROTC AND  
NON-DEGREE SEEKING GRADUATES AND THEIR DEPENDENTS  
UNIVERSITY OF NOTRE DAME

PROCESSOR STAMP DATE RECEIVED HERE



2008-157-1 & 2008-157-3

SCHOOL ID# \_\_\_\_\_

PRIMARY INSURED  
STUDENT NAME: \_\_\_\_\_

Last (Family) Name

First (Given) Name

Middle Initial

GENDER:  Male  Female  
Check one

DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

EXPECTED DATE OF GRADUATION: \_\_\_\_\_ - \_\_\_\_\_  
Month Year

MAILING ADDRESS: \_\_\_\_\_

House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route

City

County

State

ZIP Code

PERMANENT 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  
(Check One)

Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD:  Male  Female  
(Check One)

Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD:  Male  Female  
(Check One)

Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD:  Male  Female  
(Check One)

Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

First (Given) Name

M/I

Last (Family) Name

CHILD:  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.**

STUDENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

# UNIVERSITY OF NOTRE DAME

2008-157-1 & 2008-157-3

**This Enrollment Card to be used by Undergraduate Students, Non-degree seeking Graduate Students and ROTC Students only. Dependents may be insured under either Plan I or Plan II but not both.**

Each eligible Dependent has a choice of one of the benefit Plans. Plan I (Policy number 2008-157-1) has higher benefits and higher premiums than Plan II (Policy number 2008-157-3). Make your selection carefully, you cannot upgrade or downgrade coverage after the initial purchase of the plan for the policy year. Please be aware that if you choose to upgrade coverage in any subsequent policy year, a new Pre-existing Condition exclusion and waiting period may apply.

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF NOTRE DAME

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			
<b><u>PLAN I (2008-157-1)</u></b>			
<b><u>INSURED CATEGORY:</u></b>			
<input type="checkbox"/> Undergraduate			
<input type="checkbox"/> Other (ROTC & Non-degree Seeking Graduates only)			
<u>PERIOD CODES</u>	<u>Annual (A-)</u>	<u>Spring/Summer (J-)</u>	<u>Summer (S-)</u>
<b><u>ID CODES</u></b>			
A Student	<input type="checkbox"/> \$ 1,468.00	<input type="checkbox"/> \$ 853.00	<input type="checkbox"/> \$ 370.00
B Spouse	<input type="checkbox"/> \$ 7,216.00	<input type="checkbox"/> \$ 4,191.00	<input type="checkbox"/> \$ 1,819.00
C Each Child	<input type="checkbox"/> \$ 2,791.00	<input type="checkbox"/> \$ 1,621.00	<input type="checkbox"/> \$ 703.00
D All Children	<input type="checkbox"/> \$ 5,164.00	<input type="checkbox"/> \$ 2,999.00	<input type="checkbox"/> \$ 1,302.00
F All Dependents	<input type="checkbox"/> \$11,435.00	<input type="checkbox"/> \$6,642.00	<input type="checkbox"/> \$2,882.00
<b><u>PLAN II (2008-157-3)</u></b>			
<b><u>INSURED CATEGORY:</u></b>			
<input type="checkbox"/> Undergraduate			
<input type="checkbox"/> Other (ROTC & Non-degree Seeking Graduates only)			
<u>PERIOD CODES</u>	<u>Annual (A-)</u>	<u>Spring/Summer (J-)</u>	<u>Summer (S-)</u>
<b><u>ID CODES</u></b>			
A Spouse	<input type="checkbox"/> \$3,994.00	<input type="checkbox"/> \$ 2,320.00	<input type="checkbox"/> \$ 1,007.00
B All Children	<input type="checkbox"/> \$2,109.00	<input type="checkbox"/> \$ 1,225.00	<input type="checkbox"/> \$ 532.00
D All Dependents	<input type="checkbox"/> \$5,452.00	<input type="checkbox"/> \$ 3,167.00	<input type="checkbox"/> \$ 1,374.00
<b><u>EFFECTIVE / EXPIRATION PERIODS:</u></b>			
Annual	<input type="checkbox"/>	08-15-2008 to 08-14-2009	
Spring/Summer	<input type="checkbox"/>	01-15-2009 to 08-14-2009	
Summer	<input type="checkbox"/>	05-15-2009 to 08-14-2009	

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **StudentResources** 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 UnitedHealthcare **StudentResources**, PO Box 809026, Dallas TX 75380-9026. 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 \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month Year
AUTHORIZED SIGNATURE _____		DATE _____
<b>OR</b> PAID BY CHECK # _____		AMOUNT PAID \$ _____