

PLEASE CHECK ALL APPROPRIATE BOXES:

Policy # 2008-157-1

ELIGIBILITY: All Insured Persons who have been continuously insured under the school's regular student Policy for at least 6 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy and who are not eligible for other insurance coverage including Medicare. The maximum length of coverage under the continuation Plan is 6 months. Coverage date not to extend beyond August 14, 2009 at the rate listed. **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

Insured Category: CONTINUATION

Check the Appropriate Box(es)

Monthly (MX)

- G. Student \$184.00
- H. Spouse \$902.00
- I. Each Child \$349.00

To Calculate Your Rate:
Rate x # of months eligible = Amount Due
Example: \$175 x 3 months = \$525.00

CALCULATION FOR MONTHLY PREMIUM

MONTHLY RATE (ABOVE) \$ _____
 MULTIPLY BY # OF MONTHS TO PURCHASE **X** _____
 TOTAL PREMIUM ENCLOSED \$ _____

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ EXP DATE _____ / _____
 VISA or MASTERCARD
 Card# _____
 SIGNATURE OF CARDHOLDER _____
OR PAID BY CHECK # _____
 AMOUNT PAID \$ _____

Payment Instructions: Make check or money order payable to Student Resources, 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 United Healthcare **Student**Resources, 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 payment whether or not a renewal notice is received**

CLAIM INSTRUCTIONS

Claims should be submitted to the company within 90 days after date of treatment. Please mail all medical and hospital bills along with the insured student's name and patient's name, ID number, address, and the name of the college or university under which the student is insured to the address listed on this card.

Send claims to: United Healthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025

For electronic submission: Emdeon (formerly WebMD) #: 74227

For emergencies while traveling, call Scholastic Emergency Services at 1-877-488-9833 in the US, 1-609-452-8570 Collect outside the US. Reference # 01-AA-SID-01031.

For Hospital pre-admission notification call Avidyn at 1-877-295-0720.

NOTICE TO ALL HEALTHCARE PROVIDERS

This card is not a guarantee of coverage. For information concerning coverage, co-payment and claims instructions, please call Customer Service at the number listed on the front of this card. www.uhcsr.com