

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

**UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION STUDENT/DEPENDENT INSURANCE ENROLLMENT FORM**



MARQUETTE UNIVERSITY

2009-1529-6

SCHOOL ID# _____

PRIMARY INSURED
STUDENT NAME: _____

Last (Family) Name

First (Given) Name

Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ PROGRAM COMPLETION DATE _____ - _____
Check one Month Day Year Month Year

U.S. MAILING ADDRESS: _____
House/Building Number and Street Name

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

City

County

State

ZIP Code

PERMANENT FOREIGN ADDRESS: _____
House/Building Number and Street Name

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

City

Country

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 form; 2) Rates are not pro-rated other than as listed on this enrollment form; 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: _____

ELIGIBILITY: All Insured Persons who have been continuously insured under the school's regular student policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under the Policy are eligible to continue their coverage for a period of not more than nine months under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the new policy as chosen by the school, coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year.

CAMPUS/SCHOOL ATTENDING: MARQUETTE 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:
Continuation

PERIOD CODES Monthly (MX)

ID CODES

Basic
 T. Student \$ 86.00
 U. Spouse \$211.00
 V. Each Child \$141.00

OPTIONAL MAJOR MEDICAL:

PERIOD CODES Monthly (MX)
 (\$35,000 Benefit)

ID CODES

Basic
 W. Student \$57.00
 X. Spouse \$57.00
 Y. Each Child \$57.00

PERIOD CODES Monthly (MX)
 (\$235,000 Benefit)

ID CODES

Basic
 E. Student \$90.00
 F. Spouse \$90.00
 G. Each Child \$90.00

Payment Instructions: Make check or money order payable to Student Insurance in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment form 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.**

To Calculate Your Rate:
 Rate x # of months eligible = Amount Due
 Example: \$86.00 x 3 months - \$258.00

CALCULATION FOR MONTHLY PREMIUM

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

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ VISA or MASTERCARD # _____

Expiration Date _____

 Month Year

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____