

**MARQUETTE UNIVERSITY  
CONTINUATION STUDENT INSURANCE ENROLLMENT CARD**

**United HealthCare Insurance Company  
2009-1529-3**

(PLEASE PRINT)

Student's Name  Male  Female Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Expected Graduation Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Year

Permanent US Address \_\_\_\_\_ Street or PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

E-Mail address \_\_\_\_\_

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under the Plan and cannot exceed coverage purchased by the student.

	Last Name	First Name	MI	Date of Birth	Social Security #
Spouse/Domestic Partner:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____

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. It is the student's responsibility for timely renewal payments. By signing below, 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; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.

**NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE CHECK ALL APPROPRIATE BOXES:**

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**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.

**Insured Category: CONTINUATION**

Check the Appropriate Box(es) Monthly (MX)

- Basic**  
 AA Student  \$ 95.00  
 BB Spouse  \$ 232.00  
 CC Each Child  \$ 155.00

- Optional Major Medical**  
**OPTION I** (\$35,000.00 Maximum Benefit) **OPTION II** (\$235,000.00 Maximum Benefit)  
 DD Student  \$57.00 GG Student  \$ 90.00  
 EE Spouse  \$57.00 HH Spouse  \$ 90.00  
 FF Each Child  \$57.00 II Each Child  \$ 90.00

**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 payment whether or not a renewal notice is received.**

<p><i>To Calculate Your Rate:</i>                  Rate x # of months eligible = Amount Due                  Example: \$95.00 x 3 months = \$285.00</p>	
<b>CALCULATION FOR MONTHLY PREMIUM</b>	
MONTHLY RATE (ABOVE)	\$ _____
MULTIPLY BY # OF MONTHS TO PURCHASE	X _____
TOTAL PREMIUM ENCLOSED	\$ _____
<b>PAYMENT INFORMATION</b>	
CHARGE FULL AMOUNT \$ _____	EXP DATE _____ / _____
<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD	
Card# _____	
SIGNATURE OF CARDHOLDER _____	
<b>OR</b> PAID BY CHECK # _____ AMOUNT PAID \$ _____	