

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



MISSISSIPPI STATE UNIVERSITY

2008-545-1

SOCIAL SECURITY # _____ - _____ - _____ or SCHOOL ID# _____

PRIMARY INSURED
STUDENT NAME:

_____ Last (Family) Name

_____ First (Given) Name _____ Middle Initial

GENDER: q Male q Female 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 Dependents of Students insured under the Plan.

SPOUSE: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

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.**

STUDENT'S SIGNATURE: _____ DATE: _____

CAMPUS LOCATION: MISSISSIPPI STATE 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:

ALL

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring (G-)
ID CODES			
A Student	<input type="checkbox"/> \$1,000.00	<input type="checkbox"/> \$ 366.00	<input type="checkbox"/> \$ 422.00
B Spouse	<input type="checkbox"/> \$2,881.00	<input type="checkbox"/> \$1,055.00	<input type="checkbox"/> \$1,216.00
C Each Child	<input type="checkbox"/> \$1,117.00	<input type="checkbox"/> \$ 409.00	<input type="checkbox"/> \$ 471.00

<u>PERIOD CODES</u>	Summer/Spring (J-)	Summer(S-)
A Student	<input type="checkbox"/> \$ 654.00	<input type="checkbox"/> \$ 232.00
B Spouse	<input type="checkbox"/> \$1,884.00	<input type="checkbox"/> \$ 668.00
C Each Child	<input type="checkbox"/> \$ 730.00	<input type="checkbox"/> \$ 259.00

EFFECTIVE / EXPIRATION PERIODS:

Fall	<input type="checkbox"/> 08-23-2008 to 12-31-2008
Annual	<input type="checkbox"/> 08-23-2008 to 08-22-2009
Spring	<input type="checkbox"/> 01-01-2009 to 05-31-2009
Spring/Summer	<input type="checkbox"/> 01-01-2009 to 08-22-2009
Summer	<input type="checkbox"/> 06-01-2009 to 08-22-2009

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 Holland Insurance Agency, Inc., PO Box 328, Southaven, MS 38671. 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 \$ _____ VISA or MASTERCARD # _____

Expiration Date _____
 _____ Month Year

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____