PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR VOLUNTARY PLAN
STUDENTS AND DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

MILWAUKEE SCHOOL OF ENGINEERING 2010-2325-3

SOCIAL SECURITY # _______-_____-___________ or 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: ________-______-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth :________-________-________ (Month Day Year)

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | Last (Family) Name

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

____
First (Given) Name | M/I | Last (Family) Name

CHILD: ________-______-________ (Social Security Number) ❑ 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: ____________________

06-NRL

MILWAUKEE SCHOOL OF ENGINEERING 2010-2325-3

CAMPUS/SCHOOL ATTENDING: MILWAUKEE SCHOOL OF ENGINEERING

❑ **I elect to purchase Injury and Sickness insurance coverage under the University's insurance plan. Below are the choices I have made.**

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:
❑ Part-Time
❑ Graduate
❑ Domestic Full-Time Undergraduates
❑ Other - Accelerated Program

PERIOD CODES / ID CODES		Annual (A-)	First Quarter (Q1)	Second Quarter (Q2)
A	Student	❑ $1,312.00	❑ $ 328.00	❑ $ 328.00
B	Spouse	❑ $2,624.00	❑ $ 656.00	❑ $ 656.00
C	Each Child	❑ $1,968.00	❑ $ 492.00	❑ $ 492.00

PERIOD CODES / ID CODES		Third Quarter (Q3)	Foruth Quarter (Q4)
A	Student	❑ $ 328.00	❑ $ 328.00
B	Spouse	❑ $ 656.00	❑ $ 656.00
C	Each Child	❑ $ 492.00	❑ $ 492.00

EFFECTIVE / EXPIRATION PERIODS:

Annual	❑ 08-01-2010 to 07-31-2011
First Quarter	❑ 08-01-2010 to 11-20-2010
Second Quarter	❑ 11-21-2010 to 02-20-2011
Third Quarter	❑ 02-21-2011 to 05-28-2011
Fourth Quarter	❑ 05-29-2011 to 07-31-2011

Payment Instructions: Buy insurance online at www.uhcsr.com or make check or money order payable to UnitedHealthcare **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 UnitedHealthcare **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 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 $________.______