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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

WRIGHT STATE UNIVERSITY **2018-212-22**

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
SOCIAL SECURITY #:	OR STUDENT ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	EXPECTED DATE OF GRADUATION: (MONTH/YEAR)
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)		
CITY:	STATE:	ZIP CODE:
TELEPHONE #:	EMAIL ADDRESS:	

DEPENDENT INFORMATION
Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	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 Certificate of Coverage 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 Certificate of Coverage; 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.

NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Student's Signature: ______________________________ Date: ______________

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

INSURED CATEGORY: ☐ Medical

ID Codes		Annual (A-)	Fall 1(F1)	Spring/Summer (J-)
1	Student	☐ $ 2,750.00	☐ $ 1,375.00	☐ $ 1,375.00
2	Spouse	☐ $ 2,750.00	☐ $ 1,375.00	☐ $ 1,375.00
3	One Child	☐ $ 2,750.00	☐ $ 1,375.00	☐ $ 1,375.00
4	Two or more Children	☐ $ 5,500.00	☐ $ 2,750.00	☐ $ 2,750.00
5	Spouse and 2 or more Children	☐ $ 8,250.00	☐ $ 4,125.00	☐ $ 4,125.00

PLEASE CHECK THE APPROPRIATE BOX:

MEDICAL SCHOOL YEAR 1 ☐ 2 ☐ 3 ☐ 4 ☐

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 7/1/2018 to 6/30/2019
☐ Fall 1 7/1/2018 to 12/31/2018
☐ Spring/Summer 1/1/2019 to 6/30/2019

Send Enrollment Form to:

Dee Wilcox
Insurance Benefits Coordinator
3640 Col Glenn Hwy, 190 White Hall
Dayton, OH 45435