

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR OPTIONAL MAJOR MEDICAL AND
DEPENDENTS OF GRADUATE ASSISTANTS AND STUDENT ATHLETES
MARQUETTE UNIVERSITY

PROCESSOR STAMP DATE RECEIVED HERE



2009-1529-6

SCHOOL ID# _____

PRIMARY INSURED
STUDENT NAME: _____

Last (Family) Name

First (Given) Name

Middle Initial

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

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

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

City

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.**

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: _____

MARQUETTE UNIVERSITY

2009-1529-6

CAMPUS/SCHOOL ATTENDING: MARQUETTE UNIVERSITY

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

PLEASE CHECK ALL APPROPRIATE BOXES			
INSURED CATEGORY:			
<input type="checkbox"/> FULL TIME (GRADUATE ASSISTANTS)		<input type="checkbox"/> ATHLETES	
PERIOD CODES	Annual (A-)	Fall (F-)	Spring/Summer (J-)
ID CODES			
B Spouse	<input type="checkbox"/> \$1,684.00	<input type="checkbox"/> \$ 706.00	<input type="checkbox"/> \$ 978.00
C Each Child	<input type="checkbox"/> \$1,127.00	<input type="checkbox"/> \$ 472.00	<input type="checkbox"/> \$ 655.00
OPTIONAL MAJOR MEDICAL (\$35,000 Benefit)		OPTIONAL MAJOR MEDICAL (\$235,000 Benefit)	
D Student	<input type="checkbox"/> \$ 444.00	D Student	<input type="checkbox"/> \$ 697.00
E Spouse	<input type="checkbox"/> \$ 444.00	E Spouse	<input type="checkbox"/> \$ 697.00
F Each Child	<input type="checkbox"/> \$ 444.00	F Each Child	<input type="checkbox"/> \$ 697.00
EFFECTIVE / EXPIRATION PERIODS:			
Annual	<input type="checkbox"/>	08-01-2009 to 07-31-2010	
Fall	<input type="checkbox"/>	08-01-2009 to 12-31-2009	
Spring/Summer	<input type="checkbox"/>	01-01-2010 to 07-31-2010	

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 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.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION		
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month Year
AUTHORIZED SIGNATURE _____	DATE: _____	
OR PAID BY CHECK # _____	AMOUNT PAID \$ _____	