

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND DEPENDENTS
MARQUETTE UNIVERSITY

PROCESSOR STAMP DATE RECEIVED HERE



2009-1529-3

SOCIAL SECURITY # _____ - ____ - _____ or SCHOOL ID# _____
PRIMARY INSURED STUDENT NAME: _____

Last (Family) Name

First (Given) Name

Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - ____ - _____ EXPECTED DATE OF GRADUATION: _____ - ____ - _____
Check one Month Day Year 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: _____ - ____ - _____ 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 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: _____

