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UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR VISITING FACULTY/SCHOLARS AND THEIR DEPENDENTS

GEORGIA STATE UNIVERSITY 2018-201-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR SCHOLAR.		
SOCIAL SECURITY #:	SCHOOL 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 Scholar 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 SCHOLAR: 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.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

Scholar Signature: ______________________________ Date: ______________

Campus/School Attending: _____

Please print name of University. Must be completed in order for application to be processed.

☐ **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: ☐ Visiting Faculty/Scholars

ID Codes		Monthly (MX)
1	Scholar	☐ $ 169.00
2	Spouse	☐ $ 169.00
3	One Child	☐ $ 169.00
4	Two or More Children	☐ $ 338.00
5	Spouse and 2 or More Children	☐ $ 507.00

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/1/2015 to 7/31/2016

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the Insurance Company receives the application and correct premium payment.

Monthly coverage expires 1 month following receipt of your premium or July 31, 2016, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. Requested Effective Date: _____/_____/_____.

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $169.00 x 3 months = $507.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $_____

Multiply by # of months: _____

Total premium enclosed: $_____

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment form 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. The student is responsible for timely premium payments whether or not a premium notice is received.

To pay with a credit card: If you want to pay for your coverage with a credit card, complete this form and email it to SIDPremium-CustomerService@uhcsr.com or fax it to 469-229-5612. Make sure your email address is correct as we will enter your coverage request into our system and send you an email message with instructions for making your premium payment online with a credit card.