

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

MISSOURI COMMUNITY COLLEGE SYSTEM
UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



2010-202001-1

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

PERMANENT ADDRESS: _____
House/Building Number and Street Name

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

City

County

State

ZIP Code

MAILING 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: _____

MISSOURI COMMUNITY COLLEGE SYSTEM

2010-202001-1

CAMPUS LOCATION:

- East Central Campus St. Charles Community College State Fair Community College Crowder College Other

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 All

PERIOD CODES

Table with columns: Annual (A-), Fall (F-), Spring (G), Spring/Summer (J-), Summer (S-). Rows: A) Student, B) Spouse, C) Each Child.

ID CODES

OPTIONAL MAJOR MEDICAL:

- D) Student Annual (A-) \$523.00

EFFECTIVE /EXPIRATION PERIODS:

- Annual 08/01/2010 to 07/31/2011
Fall 08/01/2010 to 12/31/2010
Spring 01/01/2011 to 05/31/2011
Spring/Summer 01/01/2011 to 07/31/2011
Summer 06/01/2011 to 07/31/2011

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.

P. O. 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 payment whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

Form containing fields for CHARGE FULL, AMOUNT \$, AUTHORIZED SIGNATURE, DATE, and PAID BY CHECK #.