PROCESSOR STAMP DATE RECEIVED HERE

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY

MISSOURI COMMUNITY COLLEGE SYSTEM

ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

2010-202001-4

SOCIAL SECURITY # ______-_____-__________ or SCHOOL ID# ____________________

PRIMARY INSURED STUDENT NAME: ______________________________
Last (Family) Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: ______ - ____ - ______ (Month Day Year) EXPECTED DATE OF GRADUATION: ______ - _____ (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: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: _____ - _____ - _____ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth : _____ - _____ - _____ (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: ____________________

06--NRL

MISSOURI COMMUNITY COLLEGE SYSTEM

2010-202001-4

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	**Annual (A-)**	**Fall (F-)**	**Spring (G)**	**Spring/ Summer (J-)**	**Summer (S-)**
ID CODES					
A) Student	❑ $ 876.00	❑ $375.00	❑ $370.00	❑ $ 519.00	❑ $149.00
B) Spouse	❑ $2,192.00	❑ $937.00	❑ $925.00	❑ $1,299.00	❑ $374.00
C) Each Child	❑ $1,315.00	❑ $562.00	❑ $555.00	❑ $ 779.00	❑ $224.00

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 **Student**Resources in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to

UnitedHealthcare **Student**Resources
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

Expiration Date

CHARGE FULL AMOUNT $________________ ❑ VISA or ❑ MASTERCARD # ________________________________ ____-____

Month Year

AUTHORIZED SIGNATURE:____ DATE ________________________

OR PAID BY CHECK # ______________________ AMOUNT PAID $_________._____