NOTE: Benefits and rates are subject to review by the Centers for Medicare & Medicaid Services (CMS). We reserve the right to make any changes that CMS may require.

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DOMESTIC STUDENTS

UNIVERSITY OF WYOMING **2016-5857-1**

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
SOCIAL SECURITY #:	OR STUDENT 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:	

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.

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.

Student's Signature: ______________________________ Date: ____________

Campus/School Attending: **University of Wyoming**
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: ☐ **Domestic**

ID Codes		Annual (A-)	Fall (F-)	Spring/Summer (J-)
1	Student	☐ $ 2,044.00	☐ $ 826.00	☐ $ 1,218.00

ID Codes		Monthly (MX)
1	Student	☐ $ 170.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees may, for example, cover your school's administrative costs associated with offering this health plan.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual	08/29/2016 to	08/28/2017
☐ Fall	08/29/2016 to	01/22/2017
☐ Spring/Summer	01/23/2017 to	08/28/2017

EFFECTIVE AND TERMINATION DATES:
Coverage will become effective on the date the authorized representative receives the application and correct premium payment.

Monthly coverage expires 1 month following receipt of your premium or August 28, 2017, 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: $170.00 x 3 months = $506.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: $______________
Multiply by # of months: ______________
Total premium enclosed: $______________