

PLEASE COMPLETE THIS FORM  
IN BLOCK LETTER PRINT  
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY  
DEPENDENT ENROLLMENT FORM

PROCESSOR STAMP DATE RECEIVED HERE

[Stamp Area]

DUKE UNIVERSITY

2008-928-1

DUKE UNIQUE 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 Dependents of 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: \_\_\_\_\_

CAMPUS LOCATION: DUKE UNIVERSITY

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:**  Dependents of Domestic Students  Dependents of J-1 and F-1 International Students  
 Dependents of Psych Interns

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring (G-)	Summer (S-)
<u>ID CODES</u>				
E Spouse	<input type="checkbox"/> \$2,665.00	<input type="checkbox"/> \$ 889.00	<input type="checkbox"/> \$ 888.00	<input type="checkbox"/> \$ 888.00
F All Children	<input type="checkbox"/> \$1,514.00	<input type="checkbox"/> \$ 506.00	<input type="checkbox"/> \$ 504.00	<input type="checkbox"/> \$ 504.00
G All Dependents	<input type="checkbox"/> \$3,977.00	<input type="checkbox"/> \$1,327.00	<input type="checkbox"/> \$1,325.00	<input type="checkbox"/> \$1,325.00

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-17-2008 to 07-31-2009
Fall	<input type="checkbox"/> 08-17-2008 to 12-31-2008
Spring	<input type="checkbox"/> 01-01-2009 to 04-30-2009
Summer	<input type="checkbox"/> 05-01-2009 to 07-31-2009

**Payment Instructions for Dependents:** 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. Mail this enrollment card along with premium payment to UnitedHealthcare **StudentResources**, PO 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 payments whether or not a renewal notice is received.

**CHARGE CARD AUTHORIZATION PAYMENT INFORMATION**

CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date _____ Month - Year
AUTHORIZED SIGNATURE _____		DATE _____
<b>OR</b> PAID BY CHECK # _____		AMOUNT PAID \$ _____