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UNITEDHEALTHCARE INSURANCE COMPANY

CONTINUATION ELECTION FORM FOR DOMESTIC STUDENTS AND THEIR DEPENDENTS

MINNESOTA STATE UNIVERSITIES

2011-1757-1

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 Number and Street Name:		
CITY:	STATE:	ZIP CODE:
MAILING ADDRESS - House/Building Number 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 Students 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 STUDENT: [Coverage is effective [immediately] following the expiration of the [regular][student] [plan] and must be purchased within [14 days] after the expiration date of your student coverage. If premium is not received within [14 days], the premium will be refunded.] 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. A student who requests to cancel coverage under the Policy will receive a refund of unearned premiums as of the time of cancellation if the unearned premium is for a period of more than one month. The return of unearned premium will be delivered to the insured within 30 days following the receipt of the insured's request for cancellation.

[**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: ________________

MINNESOTA STATE UNIVERSITIES 2011-1757-1

CAMPUS LOCATION:

- ❑ Metropolitan State University Policy # 2011-1768-1
- ❑ Minnesota State University-Mankato Policy # 2011-1769-1
- ❑ St. Cloud State University Policy # 2011-1666-1
- ❑ Southwest Minnesota State University Policy # 2011-1675-1
- ❑ Winona State University Policy # 2011-1682-1

❑ **I elect to purchase Injury and Sickness insurance coverage under the College's student insurance plan. Below are the choices I have made.**

Eligibility: All Insured Persons who have been continuously insured under the school's regular student Policy for at least 4 consecutive months, who no longer meet the Eligibility requirements under the school's student Policy and who are not eligible for other insurance coverage including Medicare. The maximum length of coverage under the continuation Plan is **3** months. Coverage date not to extend beyond August 21,2012 at the rate listed.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ Continuation

PERIOD CODES		Monthly (MX) (3 month maximum)
ID CODES		
I	Continuing Student	❑ $ 297.00
J	Spouse	❑ $ 977.00
K	Each Child	❑ $ 446.00

Periods:

Monthly

❑ 08-22-2011 to 09-21-2011 ❑ 09-22-2011 to 10-21-2011
❑ 10-22-2011 to 11-21-2011 ❑ 11-22-2011 to 12-21-2011
❑ 12-22-2011 to 01-21-2012 ❑ 01-22-2012 to 02-21-2012
❑ 02-22-2012 to 03-21-2012 ❑ 03-22-2012 to 04-21-2012
❑ 04-22-2012 to 05-21-2012 ❑ 05-22-2012 to 06-21-2012
❑ 06-22-2012 to 07-21-2012 ❑ 07-22-2012 to 08-21-2012

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: $297.00 x 3 months = $891.00
(3 month maximum)

CALCULATION FOR MONTHLY PREMIUM:
Monthly premium: $_____
Multiply by # of months: _____
Total premium enclosed: $_____

PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 3 consecutive months, but not longer than the current plan year. Incorrect payment amounts will be returned and no coverage will be in effect.
If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (3 Months of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded..

Payment Instructions: Make check or money order payable to UnitedHealthcare **Student**Resources in US dollars. Mail this enrollment card along with premium payment to:

UnitedHealthcare **Student**Resources
PO Box 809026
Dallas, TX 75380-9026

Your cancelled check is your only receipt and notification of coverage. **The student is responsible for timely premium payments whether or not a premium notice is received.**