UNITEDHEALTHCARE INSURANCE COMPANY

2014-5338-1/2 - Medical

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

STUDENT AND DEPENDENT INSURANCE ENROLLMENT FORM

2014–2015 Student Health Insurance Plan

Please complete form below or enroll online at uams.myahpcare.com

Enrollment will NOT be accepted after September 30, 2014 for the Fall. See next page for more details.

(PLEASE PRINT CLEARLY or TYPE)

Student's Name	First		Middle Initial		Last			
Local & ID Card Mailing Address	Street or P.O.Box		City			State	Zip Code	
Permanent Address	Street or P.O.Box		City			State	Zip Code	
Email *(A confirmation email will be sent upon enrollment)*			**Cell or Telephone Number** ( ) —					
Male		**Female**		**Date of Birth** (Month/Day/Year) / /	**SSN** - -		**Student ID Number** *(must be provided to be processed)*	

List Dependents to be insured below. Dependent enrollment must take place at the time of student enrollment (or within 30 days if tuition billed), with the exception of newborn or adopted children. Dependent coverage is available only if the student is also insured. Dependent coverage must be the exact same coverage period of the Insured; and therefore, will expire concurrently with that of the student.

	First Name	MI	Last Name	Date of Birth (M/D/Y)	Gender (M/F)	Social Security Number
Spouse				/ /		— —
Child				/ /		— —
Child				/ /		— —

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student and cardholder acknowledges the following: **1)** Rates are not pro-rated other than as listed on this enrollment form; **2)** Student meets the eligibility requirements for this coverage as described in the brochure; **3)** If it is later determined that the student is not eligible, coverage will be deemed to have not been in force and the premium will be returned; and **4)** Other than eligibility or entry into the Armed Forces, **the premium is not refundable.** It is the student's responsibility to make a timely renewal payment. This plan is underwritten by **UnitedHealthcare Insurance Company**.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

STUDENT'S SIGNATURE: _____ DATE: _____

(Signature of Student or Parent if Student is under age 18)

CARDHOLDER'S SIGNATURE: _____ DATE: _____

Please note this enrollment form cannot be processed unless you make all your coverage selections on the reverse side

AHP-EF2(14) UAMS

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2014-5338-1/2 - Medical | **STUDENT AND DEPENDENT INSURANCE ENROLLMENT FORM**

2014–2015 Student Health Insurance Plan

Student Name_____ **Student ID Number**_____

(must be provided to be processed)

Enrollment will NOT be accepted after the Open Enrollment Period. See dates below.

PLEASE CHECK ALL APPROPRIATE BOXES:

Campus Location: ❑ College of Medicine ❑ College of Nursing ❑ College of Pharmacy ❑ College of Public Health ❑ Graduate School ❑ College of Health Professions

PERIOD RATES AND COVERAGE DATES:

Plan 1

	Annual 08/10/14 through 08/09/15	Fall 08/10/14 through 12/31/14	Spring 01/01/15 through 05/09/15	Spring/Summer 01/01/15 through 08/09/15	Summer 05/10/15 through 08/09/15
OPEN ENROLLMENT PERIODS	07/01/14-09/30/14	07/01/14-09/30/14			
Student	$ 2,230.00	$ 899.00	$ 809.00	$ 1,375.00	$ 574.00
Spouse	$ 6,148.00	$ 2,476.00	$ 2,221.00	$ 3,795.00	$ 1,581.00
Each Child	$ 3,264.00	$ 1,316.00	$ 1,182.00	$ 2,014.00	$ 840.00

Plan 2

	Annual 08/10/14 through 08/09/15	Fall 08/10/14 through 12/31/14	Spring 01/01/15 through 05/09/15	Spring/Summer 01/01/15 through 08/09/15	Summer 05/10/15 through 08/09/15
OPEN ENROLLMENT PERIODS	07/01/14-09/30/14	07/01/14-09/30/14			
Student	$ 1,434.00	$ 578.00	$ 520.00	$ 883.00	$ 369.00
Spouse	$ 5,390.00	$ 2,170.00	$ 1,946.00	$ 3,327.00	$ 1,386.00
Each Child	$ 2,746.00	$ 1,106.00	$ 993.00	$ 1,694.00	$ 706.00

(The billed amount includes administrative fees, non-insured services, and certain federal, health care fees/assessments.)

CALCULATE TOTAL PREMIUM DUE

Step 1 - Choose all desired premium above **| Step 2 -** Write the amount chosen in the applicable column(s) below
Step 3 - Calculate and submit total due.

Example: Student + Spouse = Total
($2,230 + $6,148 = $8,378)

Student Rate	Spouse Rate	All Children Rate	Total Amount Due
$	$	$	$

PAYMENT INFORMATION: Make check or money order payable to **UnitedHealthcare Insurance Company** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with premium payment to **Academic HealthPlans, P.O. Box 1605, Colleyville, TX 76034-1605 or fax to (817) 809-4701 if paying by credit card.** If you have questions, please call Academic HealthPlans at (855) 824-9679. 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.**

PAYMENT OPTIONS							
Charge Full Amount		$				Check Amount	$
❑	VISA	❑	MasterCard	❑	Discover	Check Number	
Credit Card Number						Expiration Date	____/____ Month Year

❑ **By signing this form, I hereby authorize Academic HealthPlans to initiate a credit card transaction for the payment of my premium. I understand my insurance will be cancelled if my credit card is declined. All charges will show on my credit card statement as Academic HealthPlans, Inc.**

SIGNATURE OF CARDHOLDER: _____ DATE _____

PRINTED NAME OF CARDHOLDER: _____ DATE _____

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