UnitedHealthcare **Student**Resources

Enrollment Form

Tufts University Health Sciences Schools

To be completed by the Tufts SAHA Office

Name of School/Program:	Class Year:	Effective Date of Coverage:
Type of Qualifying Event:		Qualifying Event Date:

Student Information

Last Name:	First Name:	Middle Initial:	Student ID #: 991-

Street Address:	Apt #:	City:	State:	Zip Code:

Email Address:	Telephone *#:*	Sex M/F:	Date of Birth:

Type of Coverage:

_____ Individual _____ 2 Person _____ Family

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) He/She meets the eligibility requirements for this coverage as described in the brochure; and 3) If it is later determined that the student is not eligible, the premium will be refunded. **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.**

Dependent Information

Spouse (First, Middle, Last):	Sex M/F:	Date of Birth:
Child/Dependent:	Sex M/F:	Date of Birth:
Child/Dependent:	Sex M/F:	Date of Birth:
Child/Dependent:	Sex M/F:	Date of Birth:

Student Signature (Required):	**Date:**	**SAHA Office Signature:**	**Date:**

Return this form to: Student Advisory and Health Administration Office

200 Harrison Avenue, Boston, MA 02111

Fax: 617-636-2708 Phone: 617-636-2700