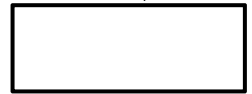


**UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS ONLY**



UNIVERSITY OF THE SCIENCES

2016-202537-1

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> 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:	

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: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	Last (Family) Name:	
CHILD SOCIAL SECURITY #:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
First (Given) Name:	Middle Initial:	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 declares that He/She meets the eligibility requirements for this coverage as described in the brochure; 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; and 5) There is no obligation to purchase this insurance.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Student's Signature: _____
(or of a parent if the student is under age 18)

Date: _____

Campus Location: UNIVERSITY OF THE SCIENCES 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: Undergraduate Graduate International

ID Codes	Annual (A-)
2 Spouse	<input type="checkbox"/> \$ 1,884.00
3 One Child	<input type="checkbox"/> \$ 1,884.00
4 Two or More Children	<input type="checkbox"/> \$ 3,768.00
5 Spouse + Two or More Children	<input type="checkbox"/> \$ 5,652.00

EFFECTIVE/EXPIRATION PERIODS: Annual 8/15/2016 to 8/14/2017**Payment Instructions:** Make check or money order payable to First Risk Advisors in US dollars. Mail this enrollment card along with premium payment to:

First Risk Advisors
67 W Court Street
Doylestown, PA 18901

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.

The State of Pennsylvania requires UnitedHealthcare Insurance Company to request the following information about the Primary Insured. If you choose not to supply this information please select the box below.

I have read the request for information and choose not to supply a response.

Race – Primary Insured's Racial Background		
<input type="checkbox"/>	W	White Alone
<input type="checkbox"/>	B	Black Alone
<input type="checkbox"/>	A	Asian Alone
<input type="checkbox"/>	I	American Indian and Alaska Native Alone
<input type="checkbox"/>	P	Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	M	Two or More Race Groups
<input type="checkbox"/>	U	Unknown

Hispanic/Latino Origin or Descent		
Hispanic/Latino origin refers to people whose origins are from Spain, Mexico or the Spanish speaking countries of Central or South America. Origins can be viewed as the ancestry, nationality lineage, or country in which the person or his/her ancestors were born before their arrival in the United States.		
<input type="checkbox"/>	1	Yes, the Primary Insured is of Hispanic origin or descent.
<input type="checkbox"/>	2	No, the Primary Insured is not of Hispanic or origin or descent.