

PLEASE COMPLETE  
THIS FORM IN BLOCK  
LETTER PRINT  
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY  
**ENROLLMENT FORM FOR  
STUDENTS AND THEIR DEPENDENTS**

**CENTRAL WASHINGTON UNIVERSITY**

2008-686-1  
2008-686-2

including:

LYNNWOOD, MOSES LAKE, DES MOINES, PIERCE COUNTY, WENATCHEE AND YAKIMA CAMPUSES

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ or SCHOOL 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

MAILING ADDRESS: \_\_\_\_\_ House/Building Number and Street Name

\_\_\_\_\_ Apt. or P.O. Box # or Rural Route \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP Code

PERMANENT 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 Students insured under the Plan.**

SPOUSE: \_\_\_\_\_ Social Security Number  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name

CHILD: \_\_\_\_\_ Social Security Number  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(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 certificate 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 certificate; 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: \_\_\_\_\_

# CENTRAL WASHINGTON UNIVERSITY

2008-686-1  
2008-686-2

**PLEASE SELECT YOUR BRANCH CAMPUS AND INSURED CATEGORY  
SO ELIGIBILITY CAN BE PROPERLY IDENTIFIED:**

**CAMPUS/SCHOOL ATTENDING:**

- |  |   |                                     |
|--|---|-------------------------------------|
| <input type="checkbox"/> Central Washington University (Main Campus) | <input type="checkbox"/> CWU-Lynnwood   | <input type="checkbox"/> CWU-Yakima |
| <input type="checkbox"/> CWU-Moses Lake                              | <input type="checkbox"/> CWU-Des Moines |                                     |
| <input type="checkbox"/> CWU-Pierce County                           | <input type="checkbox"/> CWU-Wentachee  |                                     |

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:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Domestic Graduate      | <input type="checkbox"/> Visiting Faculty/Scholars | <input type="checkbox"/> International                               |
| <input type="checkbox"/> Domestic Undergraduate | <input type="checkbox"/> Other-Research Scholars   | <input type="checkbox"/> Special - Post Graduate/Pre-Doctoral Intern |

**Each eligible student has a choice of one of the benefit Plans. Make your selection carefully – you cannot upgrade or downgrade coverage after the initial purchase of the Plan for the policy year.**

**STANDARD PLAN - 686-1**

**BASIC PERIOD CODES**

<u>ID CODES</u>	Annual (A-)	Fall (F-)	Winter (W-)	Spring (G-)	Summer (S-)
1 Student	<input type="checkbox"/> \$1,094.00	<input type="checkbox"/> \$318.00	<input type="checkbox"/> \$257.00	<input type="checkbox"/> \$254.00	<input type="checkbox"/> \$287.00
2 Spouse	<input type="checkbox"/> \$2,473.00	<input type="checkbox"/> \$719.00	<input type="checkbox"/> \$581.00	<input type="checkbox"/> \$574.00	<input type="checkbox"/> \$650.00
3 Each Child	<input type="checkbox"/> \$1,350.00	<input type="checkbox"/> \$392.00	<input type="checkbox"/> \$317.00	<input type="checkbox"/> \$313.00	<input type="checkbox"/> \$355.00

**ENHANCED PLAN - 686-2**

**BASIC PERIOD CODES**

<u>ID CODES</u>	Annual (A-)	Fall (F-)	Winter (W-)	Spring (G-)	Summer (S-)
1 Student	<input type="checkbox"/> \$1,383.00	<input type="checkbox"/> \$402.00	<input type="checkbox"/> \$325.00	<input type="checkbox"/> \$321.00	<input type="checkbox"/> \$363.00
2 Spouse	<input type="checkbox"/> \$3,125.00	<input type="checkbox"/> \$908.00	<input type="checkbox"/> \$734.00	<input type="checkbox"/> \$725.00	<input type="checkbox"/> \$821.00
3 Each Child	<input type="checkbox"/> \$1,706.00	<input type="checkbox"/> \$496.00	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$396.00	<input type="checkbox"/> \$448.00

**EFFECTIVE / EXPIRATION PERIODS:**

- |        |   |
|--------|---|
| Annual | <input type="checkbox"/> 09-24-2008 to 09-23-2009 |
| Fall   | <input type="checkbox"/> 09-24-2008 to 01-05-2009 |
| Winter | <input type="checkbox"/> 01-06-2009 to 03-30-2009 |
| Spring | <input type="checkbox"/> 03-31-2009 to 06-21-2009 |
| Summer | <input type="checkbox"/> 06-22-2009 to 09-23-2009 |

**Payment Instructions:** Make check or money order payable to UnitedHealthcare **Student**Resources 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 **Student**Resources, 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 \$ _____