

PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



CENTRAL WASHINGTON UNIVERSITY

2009-686-1 2009-686-2

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: - - -

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: - - -

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

CHILD: Social Security Number Male Female Date of Birth: - - -

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

CHILD: Social Security Number Male Female Date of Birth: - - -

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

CHILD: Social Security Number Male Female Date of Birth: - - -

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

CHILD: Social Security Number Male Female Date of Birth: - - -

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

2009-686-1
2009-686-2

**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"/> 09-23-2009 to 09-21-2010 |
| Fall | <input type="checkbox"/> 09-23-2009 to 01-04-2010 |
| Winter | <input type="checkbox"/> 01-05-2010 to 03-29-2010 |
| Spring | <input type="checkbox"/> 03-30-2010 to 06-20-2010 |
| Summer | <input type="checkbox"/> 06-21-2010 to 09-21-2010 |

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 _____	
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____		