Processor Date Stamp Received Here

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS
WAKE FOREST UNIVERSITY SCHOOL OF MEDICINE

2016-200275-1

Monthly (Monthly charge posted to your Student Account by Semesters)

TYPE OF COVERAGE REQUESTED:

☐ Graduate ☐ CRNA ☐ Medical ☐ Physician Assistants ☐ Add Coverage

Monthly Student Rate: $287.00 ☐ Drop Coverage

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
SOCIAL SECURITY #:	OR STUDENT ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ 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:	

UPON COMPLETION OF APPLICATION PLEASE SEND FORM TO STUDENT ACCOUNTING (PP1, 6TH FLOOR) FOR PROCESSING.

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 meets the eligibility requirements for this coverage as described in the brochure; 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.

NOTICE: 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.

IF ADDING COVERAGE: Insurance coverage will be in effect until the end of the semester. Please enroll online at http://studentcenter.uhcsr.com/wfsom by the end of the enrollment period each semester to maintain your coverage. (Note: Students who fail to waive coverage by the waiver deadline will be automatically enrolled by the University at the end of the enrollment/waiver period even if they do not enroll online.)

Requested Effective Date: ____/____/_____
If application is received after this requested effective date, your effective date will be the date application was received.

Students who wish to enroll their dependent(s) in the Injury and Sickness Insurance Plan must do so online at www.uhcsr.com/control or through their My Account or by filling out the Dependent Enrollment Form available at www.uhcsr.com/wfsom and mailing that in with their premium payment. Dependent coverage may only be added outside of the enrollment period for each semester if there is a qualifying event.

IF DROPPING COVERAGE: Insurance coverage will be cancelled until the end of the semester. If you are still enrolled as a student, you must waive coverage at the beginning of each semester if you still have comparable coverage and do not wish to participate in the Injury and Sickness Insurance Plan.

Requested Termination Date: ____/____/_____
If application is received after this requested termination date, your termination date will be the date application was received.

Student's Signature: _____ Date: _____