

**UNITEDHEALTHCARE INSURANCE COMPANY
CONTINUATION ENROLLMENT FORM FOR STUDENTS
AND THEIR DEPENDENTS
RUTGERS POST DOCTORATE, GRAD FELLOWS, TA'S & GA'S**

PROCESSOR STAMP DATE RECEIVED HERE

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2013-202826-1

PRIMARY INSURED Complete information below for Student.

RU ID #:				
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:		MIDDLE INITIAL:
GENDER:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:	EXPECTED DATE OF GRADUATION:	
		_____/_____/_____ MONTH DAY YEAR	_____/_____ MONTH YEAR	
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:				
CITY:		STATE:	ZIP CODE:	
MAILING ADDRESS - House/Building Number 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 is effective immediately following the expiration of the regular student plan and must be purchased within 31 days after the expiration date of your student coverage. If premium is not received within 31 days, the premium will be refunded. 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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

STUDENT'S SIGNATURE: _____

DATE: _____

CAMPUS LOCATION:

RUTGERS POST DOCTORATE, GRAD FELLOWS, TA'S & GA'S

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

Eligibility: All Insured Persons who have been continuously insured under the school's regular student Policy for at least 3 consecutive months and who no longer meet the Eligibility requirements under that Policy are eligible to continue their coverage for a period of not more than 90 days under the school's policy in effect at the time of such continuation. If an Insured Person is still eligible for continuation at the beginning of the next Policy Year, the insured must purchase coverage under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that policy year.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: Continuation

PERIOD CODES Monthly (MX)
(90 days maximum)

ID CODES

- | | |
|--------------|------------------------------------|
| A Student | <input type="checkbox"/> \$ 393.00 |
| B Spouse | <input type="checkbox"/> \$ 749.00 |
| C Each Child | <input type="checkbox"/> \$ 401.00 |

TO CALCULATE YOUR RATE:
Rate x # of months eligible = amount due
Example: \$393.00 x 3 months = \$1,179.00

CALCULATION FOR MONTHLY PREMIUM:

Monthly premium: \$ _____

Multiply by # of months: _____

Total premium enclosed: \$ _____

***PLEASE NOTE: The Continuation Privilege will allow you to purchase up to a maximum of 3 consecutive months, but not longer than the current plan year. Include full payment based on the coverage selected and the number of months chosen. Payment will not be accepted on a month-to-month basis. Incorrect payment amounts will be returned and no coverage will be in effect.**

If the student is still eligible for continuation at the beginning of the next Policy Year, the student must purchase any remaining months of coverage (3 Months of coverage less any months of coverage in the previous Policy Year) under the new policy as chosen by the school. Coverage under the new policy is subject to the rates and benefits selected by the school for that Policy Year. Please select the amount of months carefully. You will not be allowed to purchase any additional months after your initial selection. Include full payment based on the coverage selected and the number of months chosen. Payment will not be accepted on a month-to-month basis. Incorrect payment amounts will be returned and no coverage will be in effect. Coverage is effective immediately following the expiration under the previous continuation plan and must be purchased within 31 days after the expiration date of your previous continuation coverage. If premium is not received within 31 days, the premium will be refunded.

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.