

PLEASE COMPLETE THIS
FORM IN BLOCK
LETTER PRINT
USE BLACK INK

PROCESSOR STAMP DATE RECEIVED HERE



UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS
AMERICAN COLLEGE STUDENT ASSOCIATION
STUDY ABROAD PLAN

To enroll in this plan ONLINE, go to WWW.ACSA.COM

The plan cannot be purchased by residents of Massachusetts, Montana, New Hampshire, New York, New Jersey, Oregon, Puerto Rico, Vermont and Washington.

2009-2101-29

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: _____

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.**

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND /OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

STUDENT'S SIGNATURE: _____ DATE: _____

AMERICAN COLLEGE STUDENT ASSOCIATION STUDY ABROAD PLAN

2009-2101-29

CAMPUS/SCHOOL ATTENDING: _____
Please Print Name of College or University MUST BE COMPLETED IN ORDER FOR APPLICATION TO BE PROCESSED.

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ALL

Monthly (MX)

A. Student \$ 41.00 # of months _____ X \$41 = _____ Total Amount Enclosed

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective the date of receipt of this enrollment form and correct payment by the Insurance Company. Monthly coverage expires on the termination date of coverage or August 14, 2010, whichever is earlier. **COVERAGE CANNOT EXCEED 12 MONTHS.**

Please Note: If enrollment form and correct premium are received after this requested effective date, your effective date will be the date enrollment form and correct premium are received.

Requested Effective Date: _____ / _____ / _____.

Payment Instructions: Make check or money order payable to UnitedHealthcare StudentResources 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 StudentResources, 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 \$ _____ VISA or MASTERCARD # _____

Expiration Date _____
Month _____ Year _____

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____