

PLEASE COMPLETE THIS FORM IN BLOCK LETTER
PRINT
USE BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED
HERE

2009-200282-1

COMMUNITY COLLEGE OF DENVER

STUDENT ID # _____

PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name First (Given) Name Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ EXPECTED DATE OF GRADUATION: _____ - _____
Circle one Month Day Year Month Year

PERMANENT ADDRESS: _____
House/Building Number and Street Name Apt. or P.O. Box # or Rural Route

City County State Zip Code

MAILING 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 Dependents of Students insured under the Plan.

SPOUSE: _____ - _____ - _____ Male Female DATE OF BIRTH: _____ - _____ - _____
Social Security Number (Circle one) Month Day Year

First (Given) Name MI Last (Family) Name

CHILD: _____ - _____ - _____ Male Female DATE OF BIRTH: _____ - _____ - _____
Social Security Number (Circle one) Month Day Year

First (Given) Name MI Last (Family) Name

CHILD: _____ - _____ - _____ Male Female DATE OF BIRTH: _____ - _____ - _____
Social Security Number (Circle one) Month Day Year

First (Given) Name MI Last (Family) Name

CHILD: _____ - _____ - _____ Male Female DATE OF BIRTH: _____ - _____ - _____
Social Security Number (Circle one) Month Day Year

First (Given) Name MI Last (Family) Name

CHILD: _____ - _____ - _____ Male Female DATE OF BIRTH: _____ - _____ - _____
Social Security Number (Circle one) Month Day Year

First (Given) Name MI Last (Family) Name

NOTICE TO STUDENT: Coverage will be effective on the first date of the semester in which you have enrolled if you have paid premiums by the "Last Day to Enroll" on the back of this form. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form; 2) Rates are not pro-rated other than as listed on this enrollment form; 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.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

STUDENT'S SIGNATURE _____ DATE _____

Locations: (Please check the campus you are attending.)

- Community College Auraria Main Campus
- Community College East
- Community College Lowry
- Community College North
- Community College Parkway
- Community College West

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: All Regular Student

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring (G-)	Spring/Summer (J-)	Summer (S-)
<u>ID CODES</u>					
A. Student	<input type="checkbox"/> \$2,389	<input type="checkbox"/> \$1,018	<input type="checkbox"/> \$830	<input type="checkbox"/> \$1,418	<input type="checkbox"/> \$588
B. Spouse / Domestic Partner	<input type="checkbox"/> \$7,109	<input type="checkbox"/> \$3,029	<input type="checkbox"/> \$2,463	<input type="checkbox"/> \$4,222	<input type="checkbox"/> \$1,759
C. Each Child	<input type="checkbox"/> \$4,580	<input type="checkbox"/> \$1,952	<input type="checkbox"/> \$1,587	<input type="checkbox"/> \$2,720	<input type="checkbox"/> \$1,133

EFFECTIVE AND TERMINATION DATES

		<u>Last Day to Enroll</u>
Annual	08/17/2009 through 08/22/2010	09/11/2009
Fall	08/17/2009 through 01/18/2010	09/11/2009
Spring	01/19/2010 through 05/24/2010	02/05/2010
Spring/Summer	01/19/2010 through 08/22/2010	02/05/2010
Summer	05/25/2010 through 08/22/2010	06/11/2010

Payment Instructions: Coverage is only effective for Dependents if the student is actively and properly enrolled under the Student Injury and Sickness Health Plan (Policy #09-200282-1). You can pay at Community College of Denver or by sending payment by mail. **To pay at Community College of Denver:** Fill out this form and return it to Community College of Denver Admissions Registration and Records Office, Room 133, South Classroom Building, Auraria Campus. Payment can be made by check, money order, or credit card at the college. You must enroll by the "Last Day to Enroll" date above. **To pay by mail:** Make check or money order payable to "ECI" in U.S. dollars or refer to the "Charge Card Authorization Payment Information" section below to pay by credit card. Mail this enrollment form along with premium payment postmarked no later than the "Last Day to Enroll" date above to ECI, Box 264, Jefferson, CO 80456. You may also **scan and email** the form with credit card authorization to info@evansconsult.com or **fax** it to 1-719-836-3825. If you have any questions please call ECI toll-free at 866-780-3824. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

Charge will read "ECI (Student Insurance)" on Statement

CHARGED	<input type="checkbox"/> VISA or	Expiration Date
PREMIUM \$ _____	<input type="checkbox"/> MASTERCARD # _____	_____ - _____
		Month Year

This Authorization allows ECI to charge my VISA or MASTERCARD for the charged premium

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____