

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR PHYSICIAN ASSISTANT DEPENDENTS
ARCADIA UNIVERSITY

PROCESSOR STAMP DATE RECEIVED HERE

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2014-202456-61

PRIMARY INSURED Complete information below for Student.			
SOCIAL SECURITY #:		OR STUDENT ID #:	
LAST (FAMILY) NAME:		FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH: _____ / _____ / _____ MONTH / DAY / YEAR	EXPECTED DATE OF GRADUATION: _____ / _____ MONTH / YEAR	
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:			
CITY:		STATE:	ZIP CODE:

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 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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

STUDENT'S SIGNATURE: _____ (or of a parent if the student is under age 18) DATE: _____

CAMPUS LOCATION:

ARCADIA UNIVERSITY

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: International - Physician Assistant Student

Physician Assistants - Domestic Student

PERIOD CODES

Annual (A-)

ID CODES

2 Spouse \$3,345.00

3 All Children \$2,174.00

PLEASE CHECK ALL APPROPRIATE BOXES

EFFECTIVE / EXPIRATION PERIODS:

Annual

05-27-2014 to 05-26-2015

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.

The state of Pennsylvania requires UnitedHealthcare Insurance Company to request the following information about the Primary Insured. If you choose not to supply this information, please select the box below.

I have read the request for information and choose not to supply a response

Race - Primary Insured's Racial background

W	White Alone
B	Black Alone
A	Asian Alone
I	American Indian and Alaskan Native Alone
P	Native Hawaiian or Other Pacific Islander
M	Two or More Race Groups
U	Unknown

Hispanic/Latino Origin or Descent

<p>Hispanic/Latino origin refers to people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central or South America. Origins can be viewed as the ancestry, nationality lineage, or country in which the person or his/her ancestors were born before their arrival in the United States.</p>		
<input type="checkbox"/>	1	Yes, the Primary Insured is of Hispanic origin or descent.
<input type="checkbox"/>	2	No, the Primary Insured is not of Hispanic origin or descent.