

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT USE
BLACK INK

UNITEDHEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR DEPENDENTS
LINCOLN MEMORIAL UNIVERSITY -
DEBUSK COLLEGE OF OSTEOPATHIC MEDICINE

PROCESSOR STAMP DATE RECEIVED HERE



2009-611-1

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

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 Students insured under the Plan.

SPOUSE: _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name

CHILD: _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I 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.**

Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

STUDENT'S SIGNATURE: _____ DATE: _____

LINCOLN MEMORIAL UNIVERSITY - DEBUSK COLLEGE OF OSTEOPATHIC MEDICINE

2009-611-1

CAMPUS LOCATION:

Lincoln Memorial University - DeBusk College of Osteopathic Medicine

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: Medical Class of 2011 Medical 2nd Year Class of 2012 Medical Class of 2013 Medical Class of 2014

PERIOD CODES

1st Semi-Annual (I1) 2nd Semi-Annual (I2) Quarterly (QX)

ID CODES

B Spouse	<input type="checkbox"/> \$1,074.00	<input type="checkbox"/> \$1,074.00	<input type="checkbox"/> \$537.00
C All Children	<input type="checkbox"/> \$ 800.00	<input type="checkbox"/> \$ 800.00	<input type="checkbox"/> \$400.00

PERIODS:

1st Semi-Annual	<input type="checkbox"/> 08-01-2009 to 01-31-2010
2nd Semi-Annual	<input type="checkbox"/> 01-31-2010 to 07-31-2010
1st Quarter	<input type="checkbox"/> 08-01-2009 to 10-31-2009
2nd Quarter	<input type="checkbox"/> 11-01-2009 to 01-31-2010
3rd Quarter	<input type="checkbox"/> 02-01-2010 to 04-30-2010
4th Quarter	<input type="checkbox"/> 05-01-2010 to 07-31-2010

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 ____ Yr ____

AUTHORIZED SIGNATURE _____ DATE _____

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____