



# United Healthcare Student Resources Student Injury and Sickness Plan Enrollment Form

Student ID# \_\_\_\_\_ Male  Female  Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Student's Name \_\_\_\_\_  
Last (Family) Name First (Given) Name Middle Initial

Current Address \_\_\_\_\_  
Number and Street Apt # City State Zip Code

Telephone # ( ) \_\_\_\_\_ - \_\_\_\_\_ Email address \_\_\_\_\_

On Campus Resident \_\_\_\_\_ Graduate  Undergraduate  Are you on an F1 or J1 visa? \_\_\_\_\_  
Yes No (For International Students Only)

Term	Coverage Dates	Choose Your Coverage	Enrollment Ends	Student Rates
Annual	8/15/09-8/14/10	<input type="checkbox"/>	9/1/09	\$2,150
Fall Semester Only	8/15/09-12/31/09	<input type="checkbox"/>	9/1/09	\$841
Fall I	8/15/09-10/25/09	<input type="checkbox"/>	9/1/09	\$435.50
Fall II	10/26/09-12/31/09	<input type="checkbox"/>	11/1/09	\$405.50
Spring	1/1/10-5/31/10	<input type="checkbox"/>	2/1/10	\$911
Spring I	1/1/10-3/14/10	<input type="checkbox"/>	2/1/10	\$440.50
Spring II	3/15/10-8/14/10	<input type="checkbox"/>	4/1/10	\$910.50
Spring III	3/15/10-5/31/10	<input type="checkbox"/>	4/1/10	\$470.50
Spring/Summer	1/1/10-8/14/10	<input type="checkbox"/>	2/1/10	\$1351
Summer	6/1/10-8/14/10	<input type="checkbox"/>	6/25/10	\$465

Please check this box if you would like split charges (Annual Coverage only)

### I agree to the following terms and conditions as stated below:

- \* I will be enrolled in the United Healthcare Student Resources Injury and Sickness Plan for the coverage period selected above.
- \* The cost of the insurance will be added to my student account.
- \* It is my responsibility to update my coverage by contacting the Insurance Coordinator 14 days prior to the next enrollment period.
- \* I must notify the Insurance Coordinator if I am leaving the country or adding classes or enrolling in the OPT program.
- \* If I do not notify the Insurance Coordinator of any status change this will result in my being automatically enrolled into the next enrollment period without an opportunity to waive out of this assigned coverage period.

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please send this completed form to:  
 Fax it: 314-246-2399  
 Scan and Email: amyclayton13@webster.edu  
 Webster University Student Health Services  
 Attn: Amy Clayton, Insurance Coordinator  
 540 Garden Ave.  
 St. Louis, MO 63119  
 For questions, please call:  
 314-246-6922