

THE UNIVERSITY OF TENNESSEE
UNITED HEALTHCARE STUDENT INJURY AND SICKNESS INSURANCE

2017-2018 STUDENT ENROLLMENT FORM

CAMPUS LOCATION:

Chattanooga Knoxville Martin Tullahoma

STUDENT STATUS:

International Domestic

ENROLLMENT TYPE:

Undergraduate/Graduate Appointed Graduate Student Enrolling Dependent(s) Only
 Student Enrolling in Dental Only International Student Enrolling Dependent(s) Only

COVERAGE DATES: These periods are non-negotiable.

Annual, 8/1/17 – 7/31/18 Fall, 8/1/17 – 12/31/17 Spring/Summer, 1/1/18 – 7/31/18 Summer, 5/1/18 – 7/31/18

Student Information – ALL REQUIRED				
Last (Family) Name	First Name	Middle Initial	Date of Birth – MM/DD/YYYY	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		City	State	Zip Code
Social Security Number	Student ID Number	Email Address*		Telephone No.

All Student information is REQUIRED. Please allow 7 business days to process your enrollment upon receipt by our office. Failure to submit all required information may delay processing.

* Insureds may access account information/ID cards online at www.uhcsr.com using email address on file. ID cards are not automatically mailed.

Dependent Information: The following information must be provided for Dependent(s) to be insured. Dependent coverage expires concurrently with that of the primary insured.

Dependent Information						
Relationship	Gender	Social Security Number	Last (Family) Name	First Name	MI	Date of Birth – MM/DD/YYYY
Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					
Child	<input type="checkbox"/> Male <input type="checkbox"/> Female					

NOTICE TO STUDENT:

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; 4) He/She will be responsible for their own enrollment and maintaining continuous coverage by meeting applicable enrollment deadlines; and 5) 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.**

STUDENT'S SIGNATURE: _____

DATE: _____

Enrollment Options:

1. **MAIL** enrollment form and include a check or money order made payable to John H. Hildreth, CLU, LLC in U.S. dollars or refer to the Charge Card Authorization to charge your premium to Visa, Discover, or MasterCard.

Mailing Address: John H. Hildreth, CLU, LLC
 Attn: Student Health Insurance
 10259 Kingston Pike
 Knoxville, TN 37922

- 2. **FAX** enrollment form to 865-694-0362. This requires payment by credit card.
- 3. **EMAIL** enrollment form to studenthealth@hildrethins.com.
- 4. **ONLINE** enrollment can be completed by visiting www.studenthealthprograms.com. Credit card payment is required.
- 5. **IN PERSON** drop off your enrollment form at our office, located at 10259 Kingston Pike Knoxville, TN 37922.

Your cancelled check, credit card billing, or email confirmation is your receipt and notification of coverage.

Payment is due in full at time of enrollment. Optional Dental Coverage is available during Fall/Annual enrollment and must be purchased on an annual basis. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

Injury and Sickness Insurance Coverage - Medical Premiums (if adding a dependent, premiums are to be added together)				
	<input type="checkbox"/> Annual 8/1/17 - 7/31/18	<input type="checkbox"/> Fall 8/1/17 - 12/31/17	<input type="checkbox"/> Spring/Summer 1/1/18 - 7/31/18	<input type="checkbox"/> Summer 5/1/18 - 7/31/18
1. Student	\$1,884	\$785	\$1,099	\$471
2. Spouse	\$1,884	\$785	\$1,099	\$471
3. Each Child	\$1,884	\$785	\$1,099	\$471
4. All Children	\$3,768	\$1,570	\$2,198	\$942

Optional Dental Coverage (premiums are to be added together)	
	<input type="checkbox"/> Annual 8/1/17 - 7/31/18
5. Student	\$282.80
6. Spouse	\$282.67
7. 1-2 Child(ren)	\$409.83
8. 3+ Children	\$464.45

Enrollment Deadlines:

Annual Coverage..... September 20, 2017 Dental Coverage..... September 20, 2017
 Fall Coverage..... September 20, 2017 Spring + Summer Coverage..... January 31, 2018

Your enrollment form and premium payment must be received in our office by the applicable enrollment deadline. **NO EXCEPTIONS.**

PAYMENT INFORMATION	
<p>Payment Method: (check the appropriate box)</p> <p><input type="checkbox"/> Charge Card</p> <p><input type="checkbox"/> Check # _____</p> <p><input type="checkbox"/> Money Order</p> <p>Premium will not be refunded except for ineligibility or entrance into the armed forces.</p>	<p>Premium Summary:</p> <p>Medical Premium for Student from line 1 _____</p> <p>Medical Premium for Spouse from line 2 + _____</p> <p>Medical Premium for one Child from line 3 + _____</p> <p>Medical Premium for All Children from line 4 + _____</p> <p>Dental Premium for Student from line 5 + _____</p> <p>Dental Premium for Student + Spouse from line 6 + _____</p> <p>Dental Premium for Student + Child(ren) from line 7 + _____</p> <p>Dental Premium for Student + Family from line 8 + _____</p> <p style="text-align: right;">Total Premium Due = _____</p> <p>Charge Card Authorization: (An additional 2.5% will be added when paying by credit card)</p> <p>Visa / Discover / MasterCard No. _____</p> <p>CID Code (3 digit code on back of credit card) _____</p> <p>Expiration Date _____ Total Charge (Total Premium Due + 2.5% processing fee) _____</p> <p>Cardholder signature _____ Date _____</p>