

THE UNIVERSITY OF TENNESSEE

UNITEDHEALTHCARE STUDENT INJURY AND SICKNESS INSURANCE

2020-2021 STUDENT ENROLLMENT FORM

ELIGIBILITY REQUIREMENTS (continue only if student meets these requirements):

Degree seeking students taking 6+ undergraduate or 3+ graduate credit hours **with a minimum of one credit hour on campus** and students participating in a co-op program are eligible to enroll in this insurance plan on a voluntary basis. The insurance company maintains its right to investigate eligibility or student status and attendance records to verify that the Policy eligibility requirements have been met.

CAMPUS LOCATION:

- Chattanooga
 Knoxville
 Martin
 Space Institute

ENROLLMENT TYPE:

- Undergraduate Student
 Knoxville GA, GTA, GRA, or Fellow Enrolling Dependent(s) Only
 Graduate Student
 International Student Enrolling Dependent(s) Only
 Student Participating in a Co-op Program
 Dental and/or Vision, Annual Enrollment

COVERAGE DATES:

- Annual, 8/1/20-7/31/21
 Fall, 8/1/20-12/31/20
 Spring + Summer, 1/1/21-7/31/21
 Summer, 5/1/21-7/31/21

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.

Please allow 7 business days to process your enrollment upon receipt by our office. Failure to submit all required information will 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						
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: _____

PREMIUMS: (select all enrollment periods, calculate combined total, and refer to payment section below)

INJURY AND SICKNESS INSURANCE COVERAGE – MEDICAL PREMIUMS PER PERIOD (if adding a dependent, premiums are cumulative)

	Coverage Dates	ENROLLMENT DEADLINE	Student	Spouse	One Child	2+ Children	TOTAL
Annual	8/1/20 – 7/31/21	9/20/2020	<input type="checkbox"/> \$2,208	<input type="checkbox"/> \$2,208	<input type="checkbox"/> \$2,208	\$4,416	
Fall	8/1/20 – 12/31/20	9/20/2020	\$920	\$920	\$920	\$1,840	
Spring + Summer	1/1/21 – 7/31/21	1/31/2021	\$1,288	\$1,288	\$1,288	\$2,576	
Summer	5/1/21 – 7/31/21	5/31/2021	\$552	\$552	\$552	\$1,104	

OPTIONAL DENTAL AND VISION COVERAGE – ANNUAL PREMIUMS (premiums are already combined)

	Coverage Dates	ENROLLMENT DEADLINE	Student	Student + Spouse	Student + Child(ren)	Student + Family	TOTAL
Dental	8/1/20 – 7/31/21	9/20/2020	<input type="checkbox"/> \$230.32	<input type="checkbox"/> \$460.65	<input type="checkbox"/> \$619.00	<input type="checkbox"/> \$904.65	
Vision	8/1/20 – 7/31/21	9/20/2020	<input type="checkbox"/> \$147.96	<input type="checkbox"/> \$280.56	<input type="checkbox"/> \$329.04	<input type="checkbox"/> \$462.84	

COMBINED TOTAL: _____

PAYMENT: (select payment type and complete related section)

- CHECK**, payable to John H. Hildreth, CLU, LLC. Check # _____
- MONEY ORDER**, payable to John H. Hildreth, CLU, LLC. Order # _____
- E-CHECK**, 0.75% fee applies. Complete this section: Account Type (checking, savings, business): _____
Routing Number (9 Digit): _____ Bank Account #: _____
Account Holder Name: _____ Amount (Combined Total + 0.75% processing fee): _____
Account Holder Signature: _____ Date: _____
- CREDIT/DEBIT CARD** (Visa, Discover, or Mastercard), 2.5% fee applies. Complete payment authorization:
Card Number: _____ CID Code (3-digit code on back of card): _____
Expiration Date: _____ Total Charge (Combined Total + 2.5% processing fee): _____
Billing Address (if different from page 1): _____
Cardholder Signature: _____ Date: _____

WHERE TO SEND COMPLETED FORM:

1. **MAIL** enrollment form with check or money order payable to John H. Hildreth, CLU, LLC, or complete payment section for credit card or e-check payment. 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 or e-check.
3. **EMAIL** enrollment form to studenthealth@hildrethins.com. This requires payment by credit card or e-check.
4. **ONLINE** enrollment can be completed by visiting www.studenthealthprograms.com. Credit card payment is required.

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 & Vision Coverages are 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.