THE UNIVERSITY OF TENNESSEE

UNITEDHEALTHCARE STUDENT INJURY AND SICKNESS INSURANCE

2021 - 2022 OPT, VISITING FACULTY, AND SCHOLAR ENROLLMENT FORM

ELIGIBILITY REQUIREMENTS (continue only if primary insured meets these requirements)**:**

International scholars or other persons with a current passport and student visa engaged in educational activities at the University of Tennessee are eligible and may enroll in the 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.

STATUS:

☐ OPT – Optional Practical Training; non-U.S. citizen ☐ Visiting Faculty or Scholar*; non-U.S. citizen

*** Visiting Faculty and Scholars are not eligible to be seen at the Knoxville Student Health Center. Once your enrollment has been processed, log in to your account at www.uhcsr.com to find providers in the UHC Choice Plus network.**

CAMPUS LOCATION:

☐ Chattanooga ☐ Knoxville ☐ Martin ☐ Southern ☐ Space Institute

Primary Insured Information – REQUIRED				
Last (Family) Name	First Name	Middle Initial	Date of Birth – MM/DD/YYYY	Gender ☐ Male ☐ Female
Mailing Address – U.S. address only	City		State	Zip Code
Social Security or Tax ID Number – leave blank if you do not have one	Student ID or Passport Number	Email Address**		
Telephone Number	UT Department	Department Contact Name and Telephone Number		

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: Complete information below for dependents to be insured. Dependent coverage expires concurrently with that of the primary insured. Dependents without a Social Security Number or middle initial (MI) may leave these fields blank. All other information is required.

Dependent Information						
Relationship	Gender	Social Security Number	Last (Family) Name	First Name	MI	Date of Birth – MM/DD/YYYY
Spouse	☐ Male ☐ Female					
Child	☐ Male ☐ Female					
Child	☐ Male ☐ Female					
Child	☐ Male ☐ 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:

INJURY AND SICKNESS INSURANCE COVERAGE – MEDICAL PREMIUMS

Period	Premium Amount per insured	Period Description
Monthly	$200	Every day within one calendar month (the first through the last day of the month)
Weekly	$50	1 to 7 consecutive days (i.e. Sunday through Saturday, Monday through Sunday, etc.)

COVERAGE PERIOD & PREMIUM CALCULATION – PREMIUMS ARE CUMULATIVE

	Coverage Period Effective Date (not before 8/1/2021)	Coverage Period Termination Date (not after 7/31/2022)	Number of Months in coverage period	Number of Weeks in coverage period	TOTAL PREMIUM = (# Months x $200) + (# Weeks x $50)
Insured					
Spouse					
Child 1					
Child 2*					

*Maximum child premium is 2x individual rate.

COMBINED TOTAL: _____

Call 865-691-4652 or email studenthealth@hildrethins.com for assistance in determining total premium amount. Sending the incorrect premium amount for your requested coverage period may result in delayed processing time and/or modified coverage dates.

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 #_____

☐ **DIRECT DEPOSIT FROM UT**, Document Date: _____ UT Document #_____

☐ **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: _____

☐ **RECURRING PAYMENTS**, must also complete E-Check or Credit/Debit section above. Applicable processing fee applies.

Starting _____ Ending (not after 7/31/2022) _____ Monthly charge w/ fee _____

I authorize the payment method provided (e-check or credit/debit) to be processed for the total monthly premium due for myself and my dependents on or around the 1st of every month following my initial purchase and will contact John H. Hildreth, CLU, LLC to discontinue payments prior to the end date specified. I understand if payment cannot be processed my coverage will terminate immediately.

Card/Account Holder Signature: _____ Date: _____

WHERE TO SEND COMPLETED FORM:

1. **MAIL** to John H. Hildreth, CLU, LLC, Attn: Student Health Insurance, 10259 Kingston Pike, Knoxville, TN 37922.
2. **FAX** to 865-694-0362.
3. **EMAIL** enrollment form to studenthealth@hildrethins.com.

Your canceled check, credit card billing, or email confirmation is your receipt and notification of coverage.
A receipt will be emailed to you within 7 business days.