THE UNIVERSITY OF TENNESSEE

UNITEDHEALTHCARE STUDENT INJURY AND SICKNESS INSURANCE

2023-2024 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 ☐ Nashville ☐ Southern ☐ Space Institute

ENROLLMENT TYPE:

☐ Undergraduate Student
☐ Graduate Student (without assistantship)
☐ Student Participating in a Co-op Program
☐ Appointed Graduate Student Enrolling Dependent(s) Only
☐ International Student Enrolling Dependent(s) Only
☐ Dental and/or Vision, Annual Enrollment

COVERAGE DATES:

☐ Annual, 8/1/23-7/31/24 ☐ Fall, 8/1/23-12/31/23 ☐ Spring + Summer, 1/1/24-7/31/24 ☐ Summer, 5/1/24-7/31/24

Student Information - ALL REQUIRED				
Last (Family) Name	First Name	Middle Initial	Date of Birth – MM/DD/YYYY	Gender ☐ Male ☐ 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	☐ 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: (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	8/1/23 – 7/31/24	**9/20/2023**	☐ $2,880	☐ $2,880	☐ $2,880	☐ $5,760	
Fall	8/1/23 – 12/31/23	**9/20/2023**	☐ $1,200	☐ $1,200	☐ $1,200	☐ $2,400	
Spring + Summer	1/1/24 – 7/31/24	**1/31/2024**	☐ $1,680	☐ $1,680	☐ $1,680	☐ $3,360	
Summer	5/1/24 – 7/31/24	**5/31/2024**	☐ $720	☐ $720	☐ $720	☐ $1,440	

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

	Coverage Dates	ENROLLMENT DEADLINE	Student	Student + Spouse	Student + Child(ren)	Student + Family	TOTAL
Dental	8/1/23 – 7/31/24	**9/20/2023**	☐ $230.32	☐ $460.65	☐ $619.00	☐ $904.65	
Vision	8/1/23 – 7/31/24	**9/20/2023**	☐ $144.72	☐ $274.44	☐ $321.84	☐ $452.64	

COMBINED TOTAL: 0

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): $ 0.00

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): $ 0.00

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 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.

QUESTIONS? CALL 865-691-4652