

# THE UNIVERSITY OF TENNESSEE

## UNITEDHEALTHCARE STUDENT INJURY AND SICKNESS INSURANCE

### 2025-2026 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 ☐ Appointed Graduate Student Enrolling Dependent(s) Only  
☐ Graduate Student (without assistantship) ☐ International Student Enrolling Dependent(s) Only  
☐ Student Participating in a Co-op Program ☐ Dental and/or Vision, Annual Enrollment

**COVERAGE DATES:**

☐ Annual, 8/1/25-7/31/26 ☐ Fall, 8/1/25-12/31/25 ☐ Spring + Summer, 1/1/26-7/31/26 ☐ Summer, 5/1/26-7/31/26

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](http://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	8/1/25 – 7/31/26	<b>9/20/2025</b>	<input type="checkbox"/> \$2,928	<input type="checkbox"/> \$2,928	<input type="checkbox"/> \$2,928	<input type="checkbox"/> \$5,856	
Fall	8/1/25 – 12/31/25	<b>9/20/2025</b>	<input type="checkbox"/> \$1,220	<input type="checkbox"/> \$1,220	<input type="checkbox"/> \$1,220	<input type="checkbox"/> \$2,440	
Spring + Summer	1/1/26 – 7/31/26	<b>1/31/2026</b>	<input type="checkbox"/> \$1,708	<input type="checkbox"/> \$1,708	<input type="checkbox"/> \$1,708	<input type="checkbox"/> \$3,416	
Summer	5/1/26 – 7/31/26	<b>5/31/2026</b>	<input type="checkbox"/> \$732	<input type="checkbox"/> \$732	<input type="checkbox"/> \$732	<input type="checkbox"/> \$1,464	

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

	Coverage Dates	ENROLLMENT DEADLINE	Student	Student + Spouse	Student + Child(ren)	Student + Family	TOTAL
Dental	8/1/25 – 7/31/26	<b>9/20/2025</b>	<input type="checkbox"/> \$211.90	<input type="checkbox"/> \$423.80	<input type="checkbox"/> \$569.48	<input type="checkbox"/> \$832.28	
Vision	8/1/25 – 7/31/26	<b>9/20/2025</b>	<input type="checkbox"/> \$103.11	<input type="checkbox"/> \$195.54	<input type="checkbox"/> \$229.31	<input type="checkbox"/> \$332.51	

**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](mailto:studenthealth@hildrethins.com). This requires payment by credit card or e-check.
4. **ONLINE** enrollment can be completed by visiting [www.studenthealthprograms.com](http://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**