

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
INTERNATIONAL STUDENTS AND THEIR DEPENDENTS ONLY

PROCESSOR STAMP DATE RECEIVED HERE



AACC-SI COMMUNITY COLLEGES PLAN
ENROLL ONLINE: WWW.STUDENTINSURANCEAGENCY.COM

2008-200295-4

The Plan is not available to residents of Massachusetts, Montana, New Hampshire, New York, New Jersey, Oregon, Puerto Rico, Vermont and Washington.

SOCIAL SECURITY # _____ - _____ - _____ or SCHOOL ID# _____
PRIMARY INSURED
STUDENT NAME: _____
Last (Family) Name

_____ First (Given) Name Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ EXPECTED DATE OF GRADUATION: _____ - _____
Check one Month Day Year Month Year

PERMANENT ADDRESS: _____
House/Building Number and Street Name

_____ Apt. or P.O. Box # or Rural Route City County State ZIP Code

MAILING ADDRESS: _____
House/Building Number and Street Name

_____ Apt. or P.O. Box # or Rural Route City County State ZIP Code

TELEPHONE # _____ - _____ E-MAIL ADDRESS: _____

Complete information below for Dependents to be insured. Dependent coverage is available only for Students insured under the Plan.

SPOUSE: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name
CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
Social Security Number (Check One) Month Day Year

_____ First (Given) Name M/I Last (Family) Name

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. 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; and 4) 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.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND /OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

STUDENT'S SIGNATURE: _____ DATE: _____

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CAMPUS/SCHOOL ATTENDING: _____

Please Print Name of College. Must be completed in order for application to be processed.

I elect to purchase Injury and Sickness insurance coverage under the AACC-SI Community Colleges student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES			
INSURED CATEGORY: <input type="checkbox"/> INTERNATIONAL			
Period Codes	12 Months (A-) Cannot Be Purchased After 11-01-2008	6 Months (IX) Cannot Be Purchased After 05-01-2009	3 Months (QX) Cannot Be Purchased After 08-01-2009
ID CODES			
A. Student	<input type="checkbox"/> \$ 811.00	<input type="checkbox"/> \$ 406.00	<input type="checkbox"/> \$ 203.00
B. Spouse	<input type="checkbox"/> \$3,032.00	<input type="checkbox"/> \$1,516.00	<input type="checkbox"/> \$ 758.00
C. Each Child	<input type="checkbox"/> \$1,624.00	<input type="checkbox"/> \$ 812.00	<input type="checkbox"/> \$ 406.00
Effective and Termination Dates:			
Coverage will become effective the date of receipt of this application and correct payment by the Insurance Company or August 1, 2008, whichever is later. Annual coverage expires 1 year following receipt of your premium or October 31, 2009, whichever is earlier. Semi-Annual coverage expires 6 months following receipt of your premium or October 31, 2009 whichever is earlier. Quarterly coverage expires 3 months following receipt of your premium or October 31, 2009, whichever is earlier.			
Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. Requested Effective Date: _____ / _____ / _____.			

Payment Instructions: Buy insurance online at WWW.STUDENTINSURANCEAGENCY.COM or make check or money order payable to **Student Insurance in US dollars** or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to Student Insurance, 11661 San Vicente Blvd., Ste 200, Los Angeles, CA 90049-0033. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION		
CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date _____ Month - Year
AUTHORIZED SIGNATURE _____	DATE _____	
OR PAID BY CHECK # _____ AMOUNT PAID \$ _____		