UNITEDHEALTHCARE INSURANCE COMPANY

2016-2017 STUDENT INJURY AND SICKNESS INSURANCE

THE UNIVERSITY OF TENNESSEE

OPT, VISITING FACULTY, AND SCHOLAR ENROLLMENT FORM

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 ☐ Tullahoma

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		

Failure to submit all required information may 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 may leave this field 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 INSURED:

By signing, the insured 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; and 5) If it is later determined that the insured is not eligible, the premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

INSURED'S SIGNATURE: _____ **DATE**: _____

Enrollment Options:

1. **MAIL** enrollment form and include a check or money order made payable to John H. Hildreth, CLU, LLC in U.S. dollars or refer to the Charge Card Authorization to charge your premium to Visa, Discover, or MasterCard.

   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.
3. **EMAIL** enrollment form to studenthealth@hildrethins.com. This requires payment by credit card.
4. **IN PERSON -** bring your enrollment form to 10259 Kingston Pike Knoxville, TN 37922.

Your cancelled check, credit card billing, or email confirmation is your receipt and notification of coverage.

STUDENT INJURY AND SICKNESS INSURANCE MEDICAL PREMIUMS						
	☐ **Annual** 8/1/16 – 7/31/17	☐ **Fall** 8/1/16 – 12/31/16	☐ **Spring + Summer** 1/1/17 – 7/31/17	☐ **Summer** 5/1/17 – 7/31/17	☐ **Monthly*** **One calendar month**	☐ **Weekly*** **7 consecutive days**
1. Insured	$ 1,752	$ 730	$ 1,022	$ 438	$ 146	$ 34
2. Spouse	$ 1,752	$ 730	$ 1,022	$ 438	$ 146	$ 34
3. Child	$ 1,752	$ 730	$ 1,022	$ 438	$ 146	$ 34
4. All Children	$ 3,504	$ 1,460	$ 2,044	$ 876	$ 292	$ 68

Premium amounts are cumulative.

* Monthly and weekly periods are processed as follows: Monthly = every day within one calendar month (the first through the last day of the month). Weekly = 7 consecutive days (i.e. Sunday through Saturday, Monday through Sunday, etc.). Weekly periods are to be used when a coverage period does not fall within a full calendar month.

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

REQUESTED COVERAGE DATES		
	Effective Date (not before 8/1/2016)	**Termination Date** (not after 7/31/2017)
Insured		
Dependent(s)		

Payment Method:

Check the appropriate box

☐ Credit or Debit Card (Complete charge card authorization section. 2.5% charge applies.)

☐ Check # _____

☐ Money Order # _____

☐ Direct Deposit from UT:
Doc Date _____
UT Document # _____

Premium will not be refunded except for ineligibility or entrance into the armed forces.

Premium Summary:

Medical Premium for Insured from line 1 _____
Medical Premium for Spouse from line 2 + _____
Medical Premium for one Child from line 3 + _____
Medical Premium for all Children from line 4 + _____

Total Premium Due = 0

Charge Card Authorization:

(An additional 2.50% will be added when paying by credit or debit card)

Visa/Discover/MasterCard No. _____

CID Code (last 3 digit numbers printed on the signature strip on the back the credit card) _____

Expiration Date _____ **Total Charge** (Total Premium Due + 2.5% processing fee) 0

Cardholder signature _____ Date _____