

NEW
 RENEWING

Underwritten by United HealthCare Insurance Company
UNIVERSITY OF MIAMI SCHOLAR/STUDENT/OBSERVER HEALTH INSURANCE PLAN

**SCHOLAR/STUDENT/
OBSERVER
& DEPENDENT
ENROLLMENT FORM**

**2019-2020 SCHOLAR/STUDENT/OBSERVER ENROLLMENT FORM
J-1 VISITING SCHOLAR, F-1 OPT STUDENT, J-1 ACADEMIC TRAINING STUDENT, AND OBSERVER ENROLLMENT FORM**

UNITED HEALTHCARE #						
SCHOLAR/ STUDENT OR OBSERVER NAME	LAST / SURNAME					
	FIRST NAME				MIDDLE INITIAL	
UM I.D. # <i>(Please use your "C" number)</i>		DATE OF BIRTH (Month, Day, Year)		SOCIAL SECURITY # <i>(U.S. Citizens and Permanent Residents only)</i>		
U.S. MAILING ADDRESS (Use school address if none)		STREET			APARTMENT #	
CITY		STATE		ZIP		
PHONE #		EMAIL ADDRESS (REQUIRED)				
Please check appropriate box: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		Please check appropriate box: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED/DOMESTIC PARTNER		Please check appropriate box: <input type="checkbox"/> J-1 VISITING SCHOLAR <input type="checkbox"/> F-1 OPT STUDENT <input type="checkbox"/> J-1 ACADEMIC TRAINING STUDENT <input type="checkbox"/> OBSERVER		
VISA TYPE <i>(if applicable: F-1, J-1, etc.)</i>			HOME COUNTRY: <i>(if applicable)</i>			
PLEASE LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE SCHOLAR/STUDENT/OBSERVER IS ALSO ENROLLED IN THE SCHOOL PLAN. (Dependents must be enrolled on the date the scholar/student/observer is enrolled or within 30 days of date of birth, marriage, or arrival in U.S.)						
	LAST / SURNAME	FIRST NAME	MIDDLE INITIAL	GENDER	DATE OF BIRTH (Month/Day/Year)	SOCIAL SECURITY OR TAX I.D. # (U.S. Citizens and Permanent Residents only)
SPOUSE/DOMESTIC PARTNER:				<input type="checkbox"/> F <input type="checkbox"/> M		
CHILD:				<input type="checkbox"/> F <input type="checkbox"/> M		
CHILD:				<input type="checkbox"/> F <input type="checkbox"/> M		
CHILD:				<input type="checkbox"/> F <input type="checkbox"/> M		
CHILD:				<input type="checkbox"/> F <input type="checkbox"/> M		

NOTICE TO SCHOLAR/STUDENT/OBSERVER:

By signing, the scholar/student/observer acknowledges the following:

1. He/ She has carefully read the brochure and elects to enroll as indicated on this enrollment form;
2. Rates are not pro-rated;
3. He/ She meets the eligibility requirements for this coverage as described in the brochure;
4. If it is later determined that the scholar/student/observer is not eligible, the premium will be refunded;
5. Policy renewal is the responsibility of the scholar/student/observer and must be requested prior to the termination of the current policy to prevent a lapse in coverage.

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: <https://studentinsurance.usi.com> or call **800-853-5899** and select Find Your School's Plan.

PLEASE SEE OTHER SIDE FOR RATES AND PAYMENT INFORMATION. YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM. CALL (800) 853-5899 WITH QUESTIONS.

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 STUDENT, AND OBSERVER ENROLLMENT FORM**

PAYMENT IN FULL IS
 REQUIRED FOR THE TERM
 PURCHASED

SCHOLAR/STUDENT/
 OBSERVER
 & DEPENDENT
 ENROLLMENT FORM

QUARTERLY RATE AVAILABLE FROM: 7/15/19 - 8/14/20

Scholar/Student/Observer only (per quarter)	\$917.00	x 1 = (1 student)		\$ _____	I want this coverage to begin on: ____/____/____ month day year	
NOTE: Costs below are in addition to the student premium. Dependent enrollment in this plan is voluntary.						
Spouse only (per quarter)	\$917.00	x 1 = (1 spouse)	+	\$ _____		
Per Child (per quarter) (age 0-25)	\$917.00	x _____ = (enter # children)	+	\$ _____		
				TOTAL PER QUARTER (ADD 3 LINES ABOVE)	MULTIPLY BY # OF QUARTERS	YOUR TOTAL PREMIUM:
<i>Please submit your form or call to enroll during the enrollment period.</i>				= \$ _____ (Per quarter subtotal)	x _____ (number of quarters)	= \$ _____ (Amount due)

Rates include premium payable to United HealthCare Insurance Company, as well as administrative fees payable to the University of Miami and USI Student Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through Worldwide Assistance Services, Inc.

Coverage is not automatically renewed. Please see the plan summary of benefits for complete benefits and contact information.

PAYMENT METHOD (Remit in US Funds Only)

NOTE: If we are unable to process your payment (due to insufficient funds, closure of account, etc.), you and/or your dependents' insurance coverage will be terminated retroactive to the effective date of the enrolled term and you will be responsible for any claims that you've incurred.

Check/Money Order – MAKE CHECKS PAYABLE TO: USI Insurance Services National, Inc.

Credit Card: Visa MasterCard Discover

Credit Card Account Number: _____ Expires (month, year): _____

Cardholder's Name: _____
 (Enter/Print Cardholder's name exactly as it appears on card.)

ENROLL BY PHONE AT (800) 853-5899 OR

Mail, email, or fax enrollment form and payment to:

USI Student Insurance, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670 • sienrollment@usi.com • Fax (877) 612-7966

This is limited term coverage only. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated. Coverage begins at 12:01 am and ends at midnight. 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 or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

YOU MUST COMPLETE BOTH SIDES OF THE ENROLLMENT FORM AND SIGN BELOW

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements and I have read and understand the Plan Brochure. My signature below authorizes The University of Miami to provide USI Student Insurance with required information necessary to validate my enrollment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. **By signing below, the scholar/student/observer acknowledges that their dependents are not eligible for services at the student health center.**

SIGNATURE OF SCHOLAR/STUDENT/OBSERVER _____ DATE _____

USI INSURANCE SERVICES PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at (800) 853-5899 or by visiting us at <http://www.usi.com/privacy>.