UnitedHealthcare Insurance Company Enrollment Form

UnitedHealthcare Dental®

2013-1569-1

Boston Architectural College

IMPORTANT: Coverage will not begin until payment is received and processed.

Send completed application with check made payable to UnitedHealthcare **Student**Resources to:
UnitedHealthcare **Student**Resources, PO Box # 809026, Dallas, Texas 75380-9026.

SOCIAL SECURITY NUMBER	SCHOOL ID NUMBER		❑ Enroll ❑ Cancel ❑ Change ❑ Address Change ❑ Name Change Date of Change ____/____/_____
LAST NAME	FIRST NAME	M I	ENROLLEE'S DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP
TELEPHONE NUMBER Home ( )	Work ( )		❑ Male ❑ Female ❑ Single ❑ Married
PLAN PERIOD ❑ Annual	Enrollment Deadline: 10/07/13	Effective and Termination Dates: 08/23/2013 - 08/22/2014	
PLAN COVERAGE ❑ Student	❑ Student + Spouse (or Domestic Partner*)	❑ Student + Child(ren)	❑ Student + Family

INFORMATION FOR DEPENDENT COVERAGE
Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship**	If child is over age 19, please indicate status and school	
		❑ Wife ❑ Husband ❑ Domestic Partner*	❑ Student at ____________ ____________________ ❑ Handicapped	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female ❑ Other Dental Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________________ ❑ Handicapped	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female ❑ Other Dental Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________________ ❑ Handicapped	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female ❑ Other Dental Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________________ ❑ Handicapped	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female ❑ Other Dental Insurance ____________ Carrier Name
		❑ Son ❑ Daughter	❑ Student at ____________ ____________________ ❑ Handicapped	❑ Enroll ❑ Change ❑ Cancel ❑ Male ❑ Female ❑ Other Dental Insurance ____________ Carrier Name

** Domestic Partner coverage is determined by your Student Health Plan. Please confirm coverage for Domestic Partners with your medical carrier.*

***For court ordered dependent, legal documentation must be attached. Please see school representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible subscriber, please provide address on separate sheet.*

Annual	Student	$350.04	Student + Child(ren)	$851.52	Student + Spouse	$699.96	Student + Domestic Partner	$699.96	Student + Family	$1,119.96

Please send a check or money order for your premium payment, along with your completed and signed enrollment form, to the address indicated. If you would like to use a credit card to enroll, please go to www.gallagherkoster.com/BAC and select 'Voluntary Dental' from the left-hand navigation bar, and follow the 'Enroll Online' link.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage or Summary Plan Description. I understand there may be instances where treatment decisions made by my dentist or me or dental expenses which I have incurred may not be covered by my dental benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I understand that if I and/or my dependents (including my spouse or domestic Partner), if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee and may apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse or domestic partner) because of other dental coverage, I may in the future be able to enroll myself or my dependents (including my spouse or domestic partner) in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, domestic partnership, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent provided that I request enrollment within 30 days after such marriage, domestic partnership, birth, adoption, or placement for adoption.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

The Certificate provides dental benefits only. Review your Certificate carefully.

SIGNATURE:_____DATE:_____

*UnitedHealthcare Dental insurance products are either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut (except in New York), UnitedHealthcare Insurance Company of New York, Hauppauge, New York (New York only), or United Healthcare Services, Inc. UnitedHealthcare Dental Select HMO product is provided or administered by the following UnitedHealth Group companies: Dental Benefit Providers, Inc., Dental Benefit Providers of California, Inc., Dental Benefit Providers of Illinois, Inc., Dental Benefit Providers of Maryland, Inc. and/or Dental Benefit Providers of New Jersey, Inc. **