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UNITEDHEALTHCARE GLOBAL EMERGENCY MEDICAL ASSISTANCE

ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION FOR INTERNATIONAL STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF COLORADO DENVER

2016-202710-4

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:	UNIVERSITY OF COLORADO (UC) EMPLOYEE ID #:	OR STUDENT ID #:

LAST (FAMILY) NAME:	**FIRST (GIVEN) NAME:**	MIDDLE INITIAL:

GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______ / ______ / _________ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _______ / _______ MONTH YEAR

PERMANENT U.S. ADDRESS - House/Building Number and Street Name:

CITY:	STATE:	ZIP CODE:

MAILING ADDRESS - House/Building Number and Street Name:

CITY:	STATE:	ZIP CODE:

TELEPHONE #:	EMAIL ADDRESS:
HOME COUNTRY:	HOST COUNTRY:
REQUESTED PROGRAM START DATE:	HOST INSTITUTION/CENTER NAME:

HOST INSTITUTION/CENTER ADDRESS:

EMERGENCY CONTACT:	RELATIONSHIP:	PHONE #:

DEPENDENT INFORMATION: Complete information below for Dependents to be insured. Dependent coverage is only available for Students insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ _________ MONTH DAY YEAR

First (Given) Name	Middle Initial:	Last (Family) Name:

CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ _________ MONTH DAY YEAR

First (Given) Name	Middle Initial:	Last (Family) Name:

CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ _________ MONTH DAY YEAR

First (Given) Name	Middle Initial:	Last (Family) Name:

CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ _________ MONTH DAY YEAR

First (Given) Name	Middle Initial:	Last (Family) Name:

CHILD SOCIAL SECURITY #:	GENDER: ❑ MALE ❑ FEMALE	DATE OF BIRTH: ______/ ______/ _________ MONTH DAY YEAR

First (Given) Name	Middle Initial:	Last (Family) Name:

STUDENT'S SIGNATURE: ____ DATE: ______________________________

UNIVERSITY OF COLORADO DENVER

2016-202710-4

CAMPUS LOCATION:

❑ **ANSCHUTZ MEDICAL CAMPUS** ❑ **DOWNTOWN DENVER CAMPUS**

NOTE: Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations. All services must be arranged and provided by UnitedHealthcare Global, any services not arranged by UnitedHealthcare Global will not be considered for payment.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ Standalone Repatriation/Medical Evacuation

PERIOD CODES Annual (A-)

ID CODES

6	Student / Exchange Visitor	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)
7	Spouse / Civil Union	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)
8	One Child	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)
8	One Child	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)
8	One Child	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)
8	One Child	❑ $85	Start Date ____________ (mm/dd/yyyy)	End Date ____________ (mm/dd/yyyy)

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which are paid to certain non-insurer vendors or consultants by, or at the direction, of your school.

EFFECTIVE / EXPIRATION PERIODS:

08/01/2016 through 07/31/2017

You may only purchase this plan for dates that fall within the effective and expiration dates of this policy year.

TO CALCULATE YOUR RATE:

Total # People Enrolled ____________ x $85 = $ ______________________

Payment Instructions: Payment can be made by check, money order or credit card authorization. **To pay by mail:** Make check or money order payable to "ECI" in US dollars or refer to the "Charge Card Authorization Payment Information" section below to pay by credit card. Mail this enrollment form along with premium payment to ECI Services, PO Box 212, Jefferson, CO 80456. You may also **scan and email** the form with credit card authorization to info@eciservices.com or **fax** to 720-420-1878. If you have any questions please call ECI at 1-866-780-3824. Your cancelled check or credit card billing is your only receipt and notification of coverage.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION – PLEASE SPECIFY IF DEBIT CARD ❑ YES ❑ NO

CHARGE FULL ❑ VISA ❑ MASTERCARD ❑ DISCOVER ❑ AMERICAN EXPRESS Expiration Date

AMOUNT $ ____________ ______________________ Credit Card # ________ CVV Code ______ Month – ______ Year

❑ BILLING ADDRESS (select only if different from your mailing address):

STREET ADDRESS: ______________________________________

CITY: ______________________ STATE: __________ ZIP CODE: ______________

AUTHORIZED SIGNATURE ______________________ ______________________ Print Name DATE ____________

OR PAID BY CHECK # ______________________ AMOUNT PAID $ ______________