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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

2017-202710-4

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: ______________________

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:

08/01/2017 through 07/31/2018

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 $ _____