



**Loyola Marymount University
CONTINUATION INSURANCE ENROLLMENT CARD
(PLEASE PRINT)**

UNITED HEALTHCARE INSURANCE COMPANY
Policy #: 2008-794-1 or 2008-794-3

Student's Name _____ / _____ / _____ MI
 Male Female Last First

Permanent US Address _____
 Street or PO Box City State Zip

Social Security # _____ Date of Birth _____ Phone # (____) _____

Expected Graduation Date: Month _____ Date _____ E-Mail address _____

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under the Plan and cannot exceed coverage purchased by the student.

	Last Name	First Name	MI	Date of Birth	Social Security #
Spouse:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____
Child:	_____	_____	_____	_____	_____

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the Effective Date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. It is the student's responsibility for timely renewal payments. By signing below, the student 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) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Signature of Student _____ Date _____