

(PLEASE PRINT)

Name: _____ / _____ / _____ M.I. Male Female
Last First

Address: _____ City: _____ State or country: _____ Zip Code _____

Date of birth: ____/____/____ Social Security Number: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Home Country: _____ Host Country: _____ Arrival Date: _____

Requested Program Start Date: _____ Host Institution/Center name: _____

Host Institution/Center address: _____ City: _____ State or country: _____

DEPENDENT INFORMATION:

	Last Name	First Name	MI	Date of Birth	Social Security #	
Spouse:	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child:	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child:	_____	_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

NOTICE: Scholastic Emergency Services will be effective the date the correct amount due is received by United Healthcare StudentResources or the Effective Date of the coverage period, whichever is later.

Signature of Student/Scholar _____ Date _____

PLEASE CHECK ALL APPROPRIATE BOXES:

UNIVERSITY OF TEXAS SYSTEM-HSC HOUSTON

NOTE: Please visit your school's insurance coverage page at www.uhcsr.com for the Scholastic Emergency Services Global Emergency Assistance Services brochure which includes service descriptions and program exclusions and limitations. All Scholastic Emergency Services services must be arranged and provided by Scholastic Emergency Services, any services not arranged by Scholastic Emergency Services will not be considered for payment.

Participant Category: Repatriation/Medical Evacuation

Check the Appropriate Box(es) **Annual (A-)**

- 43. Student \$ 75.00
- 44. Spouse \$ 75.00
- 45. Each Child \$ 75.00

Effective: 08-24-2009 - 08-23-2010

To Calculate Your Rate:
 Rate of Participant + Rate of Participant = Amount Due
 Example: \$75.00 + \$75.00 + \$75.00 = \$225.00

Payment Instructions: Make check or money order payable to UnitedHealthcare StudentResources, in US dollars or refer to the Charge Card Authorization to charge your amount due to Visa or MasterCard. Mail this enrollment form along with your amount due to UnitedHealthcare StudentResources, PO Box 809026, Dallas, TX 75380-9026. Your cancelled check or credit card billing is your only receipt and notification of coverage.

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ EXP DATE ____/____
 VISA or MASTERCARD

Card# _____

 SIGNATURE OF CARDHOLDER

OR PAID BY CHECK # _____ AMOUNT PAID \$ _____