IMPORTANT: All late enrollees MUST complete the Prior Insurance Information section below.

Application and premium must be received within 30 days of the qualifying event below. Please read the following statements and check which option applies to you and/or your dependent.

I certify that I and/or my dependent qualifies for enrollment after September 30, 2010 for the following reason:

- [ ] Within the past 30 days I and/or my dependent have/has moved to the US from another country.
- [ ] Within the past 30 days I and/or my dependent have/has lost prior coverage due to marriage or divorce.
- [ ] Within the past 30 days I and/or my dependent have/has lost prior coverage due to age.
- [ ] Within the past 30 days I and/or my dependent have/has lost prior coverage due to _____________________________________________

[Contact UnitedHealthcare StudentResources to determine whether reason for loss of prior coverage qualifies for late enrollment.]

- [ ] Within the past 30 days my dependent was born or legally placed in my home in anticipation of an adoption or foster care placement.

Signature
Date: Month Day Year

Mail this letter along with the Late Enrollment Form to
UnitedHealthcare StudentResources, P.O. Box 809026, Dallas, TX 75380-9026.


THIS FORM MUST BE ATTACHED TO THE LATE ENROLLMENT FORM WHEN SUBMITTED IN ORDER TO SECURE ENROLLMENT IN THE DUKE STUDENT MEDICAL INSURANCE PLAN (SMIP).
UNITEDHEALTHCARE INSURANCE COMPANY
LATE ENROLLMENT FORM FOR
STUDENTS AND THEIR DEPENDENTS

DUKE UNIVERSITY
2010-928-1

DUKE UNIQUE ID# ____________________________

PRIMARY INSURED
STUDENT NAME: ____________________________________________________________

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

GENDER: ☐ Male ☐ Female

DATE OF BIRTH: ________-____-____
EXPECTED DATE OF GRADUATION: ________-____

PERMANENT ADDRESS:

House/Building Number and Street Name

Apt. or P. O. Box # or Rural Route

City

County

State

ZIP Code

DUKE MAILING ADDRESS:

House/Building Number and Street Name

Apt. or P. O. Box # or Rural Route

City

County

State

ZIP Code

TELEPHONE # _______ - _______ -

E-MAIL ADDRESS: __________________________________________________________

Complete information below for Dependents to be insured. Dependent coverage is available only for Dependents of Students insured under the Plan.

SPOUSE: _______ - _______ -

☐ Male ☐ Female

Social Security Number

(Check One)

Date of Birth: ________-____-____

CHILD: _______ - _______ -

☐ Male ☐ Female

Social Security Number

(Check One)

Date of Birth: ________-____-____

CHILD: _______ - _______ -

☐ Male ☐ Female

Social Security Number

(Check One)

Date of Birth: ________-____-____

CHILD: _______ - _______ -

☐ Male ☐ Female

Social Security Number

(Check One)

Date of Birth: ________-____-____

CHILD: _______ - _______ -

☐ Male ☐ Female

Social Security Number

(Check One)

Date of Birth: ________-____-____

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. By signing, 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; and 4) If it is later determined that the student is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

STUDENT’S SIGNATURE: ____________________________ DATE: __________________

06-NBL
DUKE UNIVERSITY

CAMPUS LOCATION: DUKE UNIVERSITY

- I elect to purchase Injury and Sickness insurance coverage under the University’s student insurance plan. Below are the choices I have made.

### STUDENT SECTION

Duke University students are required to enroll in the Duke SMIP health insurance plan for a full policy year. Your effective date, as a late enrollee, will be the first day of whichever month you enroll. For example, if you enroll on October 11, the effective date of your plan will be October 1 and you will be charged a full month’s premium. The termination date for your plan, no matter when you enroll, will be 7/31/2011.

**YOUR PREMIUM AMOUNT WILL BE CHARGED TO YOUR DUKE STUDENT ACCOUNT BY THE BURSAR’S OFFICE**

Student Rates (per month) are as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24</td>
<td>$134</td>
</tr>
<tr>
<td>24-34</td>
<td>$163</td>
</tr>
<tr>
<td>35-44</td>
<td>$230</td>
</tr>
<tr>
<td>45-54</td>
<td>$337</td>
</tr>
<tr>
<td>55 and older</td>
<td>$468</td>
</tr>
</tbody>
</table>

Please fill in: 

\[
\text{Rate} \times \text{# of months} = \text{Total Amount To Be Charged by Bursar’s Office}
\]

### DEPENDENT SECTION

Please check all appropriate boxes:

**INSURED CATEGORY:**

- Dependents of Domestic Students
- Dependents of International Students

**PERIOD CODES**

- Annual (A-)
- Fall (F-)
- Spring (G-)
- Summer (S-)

**ID CODES**

<table>
<thead>
<tr>
<th>ID Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>F Spouse</td>
<td>$3,175.00</td>
</tr>
<tr>
<td>G All Children</td>
<td>$1,804.00</td>
</tr>
<tr>
<td>H All Dependents</td>
<td>$4,738.00</td>
</tr>
</tbody>
</table>

**EFFECTIVE / EXPIRATION PERIODS:**

- Annual: 08-01-2010 to 07-31-2011
- Fall: 08-01-2010 to 12-31-2010
- Spring: 01-01-2011 to 04-30-2011
- Summer: 05-01-2011 to 07-31-2011

(See Payment Instructions for Dependents below.)

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**Payment Instructions for Dependents:** Make check or money order payable to UnitedHealthcare StudentResources in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment 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. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

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**CHARGE CARD AUTHORIZATION PAYMENT INFORMATION**

<table>
<thead>
<tr>
<th>CHARGE FULL AMOUNT</th>
<th>VISA or MASTERCARD #</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$__________________</td>
<td>_____________________</td>
<td>______ / _____</td>
</tr>
</tbody>
</table>

AUTHORIZED SIGNATURE ________________________________ DATE ________________

OR PAID BY CHECK # ___________________________ AMOUNT PAID $____________.______