

**KANSAS BOARD OF REGENTS STATE UNIVERSITIES  
GTA/GRA CONTINUATION INSURANCE ENROLLMENT FORM**

**UNITEDHEALTHCARE INSURANCE COMPANY  
2010-2011**

(PLEASE PRINT)

Student's Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First MI

Male  Female

Permanent US Address \_\_\_\_\_  
Street or PO Box City State Zip

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Expected Graduation Date: Month \_\_\_\_\_ Year \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan.

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

**Payment Instructions:** 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, P.O. Box 809026, Dallas, TX 75380-9026. Your cancelled check or credit card billing is your only receipt and notification of coverage.

**CHARGE CARD AUTHORIZATION**  
CHARGE FULL AMOUNT \$ \_\_\_\_\_ EXP DATE \_\_\_\_\_ / \_\_\_\_\_  
VISA/MASTERCARD # \_\_\_\_\_  
SIGNATURE OF CARDHOLDER \_\_\_\_\_

**PLEASE CHECK ALL APPROPRIATE BOXES:**

**INSURED CATEGORY: CONTINUATION GTA/GRA**

**LOCATIONS - Please check the school you attend:**

- |  |  |
|--|--|
| <input type="checkbox"/> Emporia State University 2010-197-3 | <input type="checkbox"/> Fort Hays State University 2010-2005-3          |
| <input type="checkbox"/> Kansas State University 2010-470-3  | <input type="checkbox"/> Pittsburg State University 2010-2009-3          |
| <input type="checkbox"/> University of Kansas 2010-471-3     | <input type="checkbox"/> University of Kansas Medical Center 2010-2070-3 |
| <input type="checkbox"/> Wichita State University 2010-180-3 |  |

**Continuation Monthly (MX) Monthly premium amount \$ \_\_\_\_\_ X \_\_\_\_\_ months of coverage**  
 G Student  \$ 84.00 **# of Months**  
 H Spouse  \$350.00  
 I All Children  \$301.00  
 = Total Premium Enclosed \_\_\_\_\_

**PERIODS:**  
Annual  08-01-2010 to 07-31-2011 Premiums are subject to change effective 08-01-10.

**ELIGIBILITY REQUIREMENT:** Insureds may pay for continuing coverage for a maximum of up to 18 months due to loss of appointment. There are certain instances that may permit an insured to receive a maximum of 36 months coverage. The Insured has a right to choose to continue benefits as long as the school maintains a plan with our Company. The Insured must exercise this right within 60 days of termination by calling UnitedHealthcare StudentResources at 1-888-344-6104 or see the designated contact for your university. Upon request a Certificate of prior creditable coverage will be provided when an employee or their dependent ceases to be covered under this policy.

The Insured must exercise this right within 60 days of termination. Application and full premium must be received within 60 days after your expiration date under the student plan from which continuation is allowed. If you do not enroll within 60 days, you are no longer eligible for coverage.

**NOTICE TO STUDENT:** If this enrollment form and appropriate premium are received by UHCSR within the 60 days outlined in the above Eligibility Requirement section, Continuation Insurance will be effective on the first day following termination of previous coverage. Subsequent premiums are due at HCSR on the first day of each month for which insurance is being purchased. UHCSR will NOT issue premium reminder notices. It is the student's responsibility to make timely renewal payments. All premiums should be submitted to the address in the Payment Instructions box above. 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 form; 2) Rates are not pro-rated other than as listed on this enrollment form; 3) He/She meets the eligibility requirements for this coverage as described above; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Premium will not be refunded except for ineligibility or entrance into the armed forces.

**Emporia State University**  
Jennifer Stout  
Human Resources  
1200 Commercial - Box 44  
Emporia, KS 66801  
phone (620) 341-5379  
fax (620) 341-6014

**Kansas State University**  
Human Resources Dept.  
103 Edwards Hall  
Manhattan, KS 66506-4801  
phone (785)532-6277  
fax (785)532-6095

**Pittsburg State University**  
Debbie Amershek  
Human Resources Dept.  
204 Russ Hall, 1701 S. Broadway  
Pittsburg, KS 66762  
phone (620) 235-4187  
fax (620) 235-6002

**University of Kansas**  
Mary Karten  
Benefits/HREO  
Carruth O'Leary Hall  
1246 W. Campus Rd, Room 135  
Lawrence, KS 66045-7505  
phone (785) 864-7346  
fax (785) 864-5200

**University of Kansas Medical Center**  
Lisa Shryock  
3901 Rainbow Blvd.  
1012 Student Center  
Kansas City, KS 66160  
phone (913) 588-2983  
fax (913) 588-1943

**Wichita State University**  
Constance Noble  
Graduate School  
1845 Fairmont  
Wichita, KS 67260-0004  
phone (316) 978-6241  
fax (316) 978-3253

**Signature of Student** \_\_\_\_\_ **Date** \_\_\_\_\_