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FRONTIERMEDEX GLOBAL EMERGENCY MEDICAL ASSISTANCE

ENROLLMENT FORM FOR STANDALONE REPATRIATION/MEDICAL EVACUATION

FOR STUDENTS AND THEIR DEPENDENTS

UNIVERSITY OF MARYLAND - COLLEGE PARK

2013-2071-91

PRIMARY INSURED Complete information below for Student.

SOCIAL SECURITY #:	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: ______________

UNIVERSITY OF MARYLAND - COLLEGE PARK **2013-2071-91**

CAMPUS LOCATION:

CAMPUS/SCHOOL ATTENDING: UNIVERSITY OF MARYLAND - COLLEGE PARK

Please Print Name of University Must be completed in order for application to be processed.

NOTE: Please visit www.uhcsr.com/frontiermedex for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations. All Global Emergency Services must be arranged and provided by FrontierMEDEX, any services not arranged by FrontierMEDEX will not be considered for payment.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ Standalone Repatriation/Medical Evacuation

PERIOD CODES	Annual (A-)	Semi/ Annual (IX)	Quarterly (QX)
ID CODES			
31. Student	❑ $ 75.00	❑ $ 38.00	❑ $ 19.00
32. Spouse	❑ $ 75.00	❑ $ 38.00	❑ $ 19.00
33. Each Child	❑ $ 75.00	❑ $ 38.00	❑ $ 19.00

NOTICE: FrontierMEDEX will be effective the date the correct amount due is received by UnitedHealthcare **Student**Resources or the Effective Date of the coverage period, whichever is later.

EFFECTIVE AND TERMINATION DATES

Coverage will become effective the date if receipt of this application and correct payment by the Insurance Company.

Please Note: If application and correct premium are received after this requested Effective Date, your Effective Date will be the date application and correct premium are received.

Requested Effective Date: _____ / _____ / _____

Payment Instructions: Make check or money order payable to First Risk Advisors in US dollars. Mail this enrollment card along with premium payment to:

First Risk Advisors
67 W. Court Street
Doylestown, PA 18901.

Your cancelled check is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.