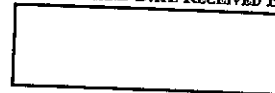


PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT
USE BLACK INK

UNITED HEALTHCARE INSURANCE COMPANY
ENROLLMENT FORM FOR
STUDENTS AND THEIR DEPENDENTS
ROYAL THAI EMBASSY

PROCESSOR STAMP DATE RECEIVED HERE



2007-513-1

SOCIAL SECURITY # _____ or SCHOOL ID# _____
PRIMARY INSURED STUDENT NAME: _____
Last (Family) Name

First (Given) Name _____ Middle Initial _____

GENDER: Male Female Other
Check one DATE OF BIRTH: _____ EXPECTED DATE OF GRADUATION: _____
Month Day Year Month Year

MAILING ADDRESS: _____
House/Building Number and Street Name
Apt. or P.O. Box # or Rural Route _____
PERMANENT ADDRESS: _____
City County State ZIP Code
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 Students insured under the Plan.

SPOUSE: _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ M/I _____ Last (Family) Name _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ M/I _____ Last (Family) Name _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ M/I _____ Last (Family) Name _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ M/I _____ Last (Family) Name _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

CHILD: _____
First (Given) Name _____ M/I _____ Last (Family) Name _____
Social Security Number _____ Male Female
Date of Birth: _____
(Check One) Month Day Year

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.**

IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND /OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

STUDENT'S SIGNATURE: _____ DATE: _____

ROYAL THAI EMBASSY

2007-513-1

CAMPUS LOCATION:
ROYAL THAI EMBASSY

CAMPUS/SCHOOL ATTENDING: _____
Please Print Name of College or University.

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

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: Self-Pay / Voluntary / Non-Funded

PERIOD CODES	Monthly (MX) Cannot Be Purchased After 8-1-2008
ID CODES	
A Student	<input type="checkbox"/> \$ 99.00
B Spouse	<input type="checkbox"/> \$ 350.00
C Each Child	<input type="checkbox"/> \$ 216.00

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective the date of receipt of this application and correct payment by the Insurance Company. Annual coverage expires 1 year following receipt of your premium or September 30, 2008, whichever is earlier. Monthly coverage expires 1 month following receipt of your premium or September 30, 2008, whichever is earlier.

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 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.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date ____ - ____ Month Year
AUTHORIZED SIGNATURE _____	DATE _____	
OR PAID BY CHECK # _____	AMOUNT PAID \$ _____	