

United HealthCare Insurance Company
2008-2300-21

ACSA - STUDENT CARE ASSOCIATION - Koster Insurance Agency
STUDENT INSURANCE ENROLLMENT CARD

The Plan cannot be purchased by residents of Hawaii, New Jersey, New York, Oregon, Massachusetts & Washington.

(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 _____ Date _____ E-Mail address _____

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan and cannot exceed coverage purchased by the student.

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

Payment Instructions: Make check or money order payable to Koster Insurance Agency 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 Koster Insurance Agency, P.O. Box 845663, Boston, MA 02284-5663. Your cancelled check or credit card billing is your only receipt and notification of coverage. An effort will be made to send premium renewal notices if paying by installments. It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.

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

Detach and Retain for your records
2008-2009 Identification Card
United HealthCare Insurance Company

Insured (Name of Student)
If a premium has been paid, the Student whose name appears above has been insured under a policy issued to:

ACSA - Student Care Association
Koster Insurance Agency
2008-2300-21

97-ID

PLEASE CHECK ALL APPROPRIATE BOXES:

ACSA-KIA 2008-2300-21

School Code: 0810 (Company Use Only)

Name of School: _____
 (Print Full Name of School - DO NOT ABBREVIATE)

DOMESTIC

INTERNATIONAL

| | Monthly (MX) | | Monthly (MX) |
|----------------------------|--|----------------------------|--|
| UNDER AGE 24 | | UNDER AGE 24 | |
| 1. Student | <input type="checkbox"/> \$ 147.00 | 21. Student | <input type="checkbox"/> \$ 129.00 |
| 2. Spouse | <input type="checkbox"/> \$ 679.00 | 22. Spouse | <input type="checkbox"/> \$ 590.00 |
| 3. All Children | <input type="checkbox"/> \$ 272.00 | 23. All Children | <input type="checkbox"/> \$ 236.00 |
| 4. Optional Major Medical | <input type="checkbox"/> \$ 24.00 (Student Only) | 24. Optional Major Medical | <input type="checkbox"/> \$ 18.00 (Student Only) |
| AGES 24 to 30 | | AGES 24 to 30 | |
| 5. Student | <input type="checkbox"/> \$ 190.00 | 25. Student | <input type="checkbox"/> \$ 158.00 |
| 6. Spouse | <input type="checkbox"/> \$ 943.00 | 26. Spouse | <input type="checkbox"/> \$ 943.00 |
| 7. All Children | <input type="checkbox"/> \$ 272.00 | 27. All Children | <input type="checkbox"/> \$ 236.00 |
| 8. Optional Major Medical | <input type="checkbox"/> \$ 24.00 (Student Only) | 28. Optional Major Medical | <input type="checkbox"/> \$ 18.00 (Student Only) |
| AGES 31 to 40 | | AGES 31 to 40 | |
| 9. Student | <input type="checkbox"/> \$ 272.00 | 29. Student | <input type="checkbox"/> \$ 236.00 |
| 10. Spouse | <input type="checkbox"/> \$ 982.00 | 30. Spouse | <input type="checkbox"/> \$ 982.00 |
| 11. All Children | <input type="checkbox"/> \$ 272.00 | 31. All Children | <input type="checkbox"/> \$ 236.00 |
| 12. Optional Major Medical | <input type="checkbox"/> \$ 24.00 (Student Only) | 32. Optional Major Medical | <input type="checkbox"/> \$ 18.00 (Student Only) |
| AGES 41 to 50 | | AGES 41 to 50 | |
| 13. Student | <input type="checkbox"/> \$ 493.00 | 33. Student | <input type="checkbox"/> \$ 429.00 |
| 14. Spouse | <input type="checkbox"/> \$1,004.00 | 34. Spouse | <input type="checkbox"/> \$1,004.00 |
| 15. All Children | <input type="checkbox"/> \$ 272.00 | 35. All Children | <input type="checkbox"/> \$ 236.00 |
| 16. Optional Major Medical | <input type="checkbox"/> \$ 24.00 (Student Only) | 36. Optional Major Medical | <input type="checkbox"/> \$ 18.00 (Student Only) |
| AGES 51 to 64 | | AGES 51 to 64 | |
| 17. Student | <input type="checkbox"/> \$ 911.00 | 37. Student | <input type="checkbox"/> \$ 802.00 |
| 18. Spouse | <input type="checkbox"/> \$1,213.00 | 38. Spouse | <input type="checkbox"/> \$1,213.00 |
| 19. All Children | <input type="checkbox"/> \$ 272.00 | 39. All Children | <input type="checkbox"/> \$ 236.00 |
| 20. Optional Major Medical | <input type="checkbox"/> \$ 24.00 (Student Only) | 40. Optional Major Medical | <input type="checkbox"/> \$ 18.00 (Student Only) |

Coverage will be effective the date this application and correct payment is received. If a later date is desired, please indicate as follows: I have enclosed \$ _____ for _____ months of coverage.
 # of Months

PERIODS BY MONTH
 (PLEASE CHECK ALL THAT APPLY)**

NO REFUNDS

| | | | | | |
|----------|---|-----------|---|---------|---|
| August | <input type="checkbox"/> 08-01-2008 to 09-01-2008 | September | <input type="checkbox"/> 09-01-2008 to 10-01-2008 | October | <input type="checkbox"/> 10-01-2008 to 11-01-2008 |
| November | <input type="checkbox"/> 11-01-2008 to 12-01-2008 | December | <input type="checkbox"/> 12-01-2008 to 01-01-2009 | January | <input type="checkbox"/> 01-01-2009 to 02-01-2009 |
| February | <input type="checkbox"/> 02-01-2009 to 03-01-2009 | March | <input type="checkbox"/> 03-01-2009 to 04-01-2009 | April | <input type="checkbox"/> 04-01-2009 to 05-01-2009 |
| May | <input type="checkbox"/> 05-01-2009 to 06-01-2009 | June | <input type="checkbox"/> 06-01-2009 to 07-01-2009 | July | <input type="checkbox"/> 07-01-2009 to 07-31-2009 |

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. It is the student's responsibility for timely renewal payments. 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 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; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than Eligibility, the premium is not refundable.
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Student _____ Date _____

CLAIM INSTRUCTIONS
 Claims must be submitted to the Company within 90 days after date of treatment. Please mail all medical and hospital bills along with the patient's name and insured student's name, address, Social Security Number and name of the university under which the student is insured to P.O. Box 809025, Dallas, Texas 75380-9025. Telephone 1-800-505-5450 or 1-469-229-6700.

NOTICE TO ALL HEALTH CARE PROVIDERS
 This card is not a guarantee of coverage. For information concerning coverage, co-payment and claim instructions, please call Customer Service at 1-800-767-0700.

