



AFFINITY  
PROGRAM  
PARTNER



## ACSI Student Insurance Application Instructions

Thank you for considering UnitedHealthcare **StudentResources** for your student insurance needs.

### **Page 1 - School Application Form, Elections and Signatures** *(Return this page)*

Section 1 – Please complete the school contact information including a shipping address if different from mailing address.

Section 2 – Please complete this entire box. If an item does not apply to you, please mark with “N/A” in the field.

Section 3 – Please complete this section after you have selected your coverage and determined your premium amount from the Rate Calculation Worksheet on page 2. In addition to the Voluntary coverage choice, select only one At-School Accident plan and enter the dollar amount from the grand total on page 2.

Section 4 – Please have an authorized person sign the form and keep a copy for your files.

### **Page 2 - Insurance Premium Rate Calculation Worksheet** *(Return this page)*

Carefully review the enclosed plan information or view your options within the “Products” tab at [www.ACSInsurance.com](http://www.ACSInsurance.com). This worksheet shows rates for the mandatory At-School Accident plans only. There are two options for plans which do not include athletics and activities and there are two options for plans which do include athletics and activities. Complete the form by choosing a plan and entering the number of students per grade level. Multiply each student count by the applicable rate to calculate your subtotals. Then add all of the right hand column figures to reach your Total Premium Due. Please copy this grand total back to section 2 on page 1 (School Application page). Your worksheet must be returned with the full application.

### **Page 3 - Voluntary Rates & Parent Information Supply Requisition** *(Return this page)*

While on the “Products” tab at [www.ACSInsurance.com](http://www.ACSInsurance.com), please review the opportunities to make additional student insurance coverage available to parents to purchase directly from UnitedHealthcare on a voluntary basis. UnitedHealthcare **StudentResources** will make flyers available to you to promote these programs and encourage parents to enroll online. Please complete the supply requisition form and indicate your preferred delivery date for the voluntary plan flyers. (Use date when someone can sign for delivery.)

### **State Specific Mandatory Offers of Coverage Page** *(Return this page – if applicable)*

The Mandatory Offers of Coverage page will appear in this application if applicable to your state. You are not required to add this extra coverage, but UnitedHealthcare Insurance Company is required to provide you with the offer to elect the coverage. Electing any state mandated optional coverage may result in an adjustment/increase in premium. You should return the completed and signed form with your decision(s) to elect or decline coverage clearly marked on the form.

#### **Mail ALL completed and signed forms to:**

UnitedHealthcare **StudentResources**  
Attn: K12 Sales  
P.O. Box 42299  
St. Petersburg, FL 33742-9936

**Payment Note** - You may mail a check with your application, or UnitedHealthcare **StudentResources** will send you an invoice after your application is processed.

For more information on UnitedHealthcare **StudentResources**' student insurance products or for assistance with your application, please call 800-237-0903 x 6281

# UnitedHealthcare Insurance Company

P.O. Box 42299, St. Petersburg, FL 33742

## Mail ALL completed and signed forms to:

UnitedHealthcare **StudentResources**  
Attn: K12 Sales  
P.O. Box 42299  
St. Petersburg, FL 33742-9936

**Payment Note** - You may mail a check with your application, or UnitedHealthcare **StudentResources** will send you an invoice after your application is processed.

PLEASE TYPE OR PRINT

### Section 1

Name of School: \_\_\_\_\_ Policy #: \_\_\_\_\_  
(leave blank if unknown)  
Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Physical address for shipping (if different): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Section 2 School Information

Estimated 2010-2011 School Enrollment: \_\_\_\_\_ (Total number of students)  
Grades (Mark one):  (PK - 12)  (E) Elementary School  (M) Middle School  
 (EM) Elementary & Middle School  (MH) Middle & High School  
 (H) High School

Effective Date/First Class Day: \_\_\_\_\_ Last Class Day: \_\_\_\_\_

**Note: Sports/Athletics/Activities coverage (including Football) begins July 1.**

### High School Football Information (complete if applicable)

Is Offseason Program Permitted? \_\_\_\_\_ Football Effective: \_\_\_\_\_ to \_\_\_\_\_  
Is Contact Practice Permitted? \_\_\_\_\_ (leave blank if unknown)  
Who pays Football Premium?  School or  Parents

### Section 3 Coverage Selected and Premium Calculation (See worksheet on page 2 for calculating your premium.)

Select only one plan from plans 1-4 for all students. All enrolled students must be covered.

- Plan 1 - At-School Accident - Excluding Athletics & Activities - \$10,000 Maximum Benefit Premium \$ \_\_\_\_\_  
 Plan 2 - At-School Accident - Excluding Athletics & Activities - \$25,000 Maximum Benefit Premium \$ \_\_\_\_\_  
 Plan 3 - At-School Accident - Including Athletics & Activities - \$10,000 Maximum Benefit Premium \$ \_\_\_\_\_  
 Plan 4 - At-School Accident - Including Athletics & Activities - \$25,000 Maximum Benefit Premium \$ \_\_\_\_\_  
 Voluntary Coverage - Optional for parents - No cost to school. You may select this in addition to one At-School Accident plan.

*Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

**Section 4** We hereby apply for the plans of insurance selected above. We understand that insurance will be in force if this is accepted by UnitedHealthcare Insurance Company, and the required premium is received by UnitedHealthcare **StudentResources** when due.

X \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Signature of Official Authorized to Contract for School

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Agent Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
UnitedHealthcare **StudentResources** representative Agent Name: Mandy Lance Agent #: 5594

**Please include a copy of this signature page with your completed application by mail.**

For assistance with your application, please call 800-237-0903 x 6281.

# UnitedHealthcare Insurance Company

## Insurance Premium Rate Calculation Worksheet

**Mandatory Rates** – At-School Accident coverage for all enrolled students

**Products:** ACSI Accident/Injury - Usual and Customary 2010/2011 Options Plans 1-4

Select only one plan for entire school. Multiply your estimated quantity of students per grade level by the rate per student. Tally the right hand column for Total Premium Due. Re-write the total premium in the appropriate space on the application (page 1, section 3). **Please include a copy of this worksheet with your completed application by mail to UnitedHealthcare StudentResources, Attn: K12 Sales, P.O. Box 42299, St. Petersburg, FL 33742-9936.**

School Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Select Plan 1, 2, 3 or 4 for your school. All enrolled students must be covered.**

**Plan 1** - At-School Accident with no sports coverage (Excludes Athletics & Activities) - \$10,000 Maximum Benefit

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
<b>A</b> Pre K – K	_____	x	\$2.10	=	\$ _____
<b>B</b> Grades 1-6	_____	x	\$5.30	=	\$ _____
<b>C</b> Grades 7-8	_____	x	\$5.30	=	\$ _____
<b>D</b> Grades 9-12	_____	x	\$6.95	=	\$ _____
<b>E</b> Teachers/Admin.	_____	x	\$12.60	=	\$ _____
<b>F</b> Overnight Field Trips - \$210 per school/school year (if applicable)				=	\$ _____
<b>Total Premium Due (for the benefits shown above) Add A – F</b>					<b>\$ _____</b>

**Plan 2** - At-School Accident with no sports coverage (Excludes Athletics & Activities). - \$25,000 Maximum Benefit

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
<b>A</b> Pre K – K	_____	x	\$2.40	=	\$ _____
<b>B</b> Grades 1-6	_____	x	\$5.85	=	\$ _____
<b>C</b> Grades 7-8	_____	x	\$5.85	=	\$ _____
<b>D</b> Grades 9-12	_____	x	\$7.50	=	\$ _____
<b>E</b> Teachers/Admin.	_____	x	\$15.25	=	\$ _____
<b>F</b> Overnight Field Trips - \$210 per school/school year (if applicable)				=	\$ _____
<b>Total Premium Due (for the benefits shown above) Add A – F</b>					<b>\$ _____</b>

**Plan 3** - At-School Accident with sports coverage (Includes Athletics & Activities). - \$10,000 Maximum Benefit Sports excludes interscholastic football. Football coverage requires a separate premium per player (see letter E below). High School Football coverage is available only with plans 3 or 4.

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
<b>A</b> Pre K – K	_____	x	\$2.10	=	\$ _____
<b>B</b> Grades 1-6	_____	x	\$5.30	=	\$ _____
<b>C</b> Grades 7-8	_____	x	\$9.75	=	\$ _____
<b>D</b> Grades 9-12	_____	x	\$12.85	=	\$ _____
<b>E</b> Gr. 9-12 Football	_____	x	\$76.65	=	\$ _____
<b>F</b> Teachers/Admin.	_____	x	\$12.60	=	\$ _____
<b>G</b> Overnight Field Trips - \$210 per school/school year (if applicable)				=	\$ _____
<b>Total Premium Due (for the benefits shown above) Add A – G</b>					<b>\$ _____</b>

**Plan 4** - At-School Accident with sports coverage (Includes Athletics & Activities). - \$25,000 Maximum Benefit Sports excludes interscholastic football. Football coverage requires a separate premium per player (see letter E below). High School Football coverage is available only with plans 3 or 4.

Grade Level	Est. # of Students	x	Rate per Student	=	Premium Subtotal
<b>A</b> Pre K – K	_____	x	\$2.40	=	\$ _____
<b>B</b> Grades 1-6	_____	x	\$5.85	=	\$ _____
<b>C</b> Grades 7-8	_____	x	\$11.35	=	\$ _____
<b>D</b> Grades 9-12	_____	x	\$19.80	=	\$ _____
<b>E</b> Gr. 9-12 Football	_____	x	\$92.60	=	\$ _____
<b>F</b> Teachers/Admin.	_____	x	\$15.25	=	\$ _____
<b>G</b> Overnight Field Trips - \$210 per school/school year (if applicable)				=	\$ _____
<b>Total Premium Due (for the benefits shown above) Add A – G</b>					<b>\$ _____</b>

**Voluntary Rates** - See Voluntary Rate page for details on voluntary 24-Hour Accident and Injury & Sickness plans.

## UnitedHealthcare Insurance Company Voluntary Rates

Plan Description	Premium per Student
24-Hour Accident with Extended Dental Coverage - High Option	\$102.00
24-Hour Accident with Extended Dental Coverage - Low Option	\$69.00
Injury and Sickness per policy year	\$588.00
Injury and Sickness per 3 month period	\$147.00
Injury and Sickness per 2 month period	\$98.00

---

### Parent Information Supply Requisition

If you elect to offer additional coverage for parents to purchase on a voluntary basis (at no extra cost to the school), UnitedHealthcare **StudentResources** will provide informational flyers to the school to make available to parents. The 2010/2011 plan options offer two levels of coverage for 24-Hour Accident and a health plan for Injury and Sickness. Enrollment may be completed by parents online at [www.K12StudentInsurance.com](http://www.K12StudentInsurance.com) after July 1, 2010.

By your request below, UnitedHealthcare **StudentResources** will ship a supply of flyers that you may hand out to every student with other parental information on the first day of school and/or you may make the flyers available as a "take-one" item within an area likely to have high parent traffic. Quantity of flyers requested should be the same number used as your estimated total number of students on the application (page 1, section 2).

#### **Voluntary Plan Flyer Supply Requisition** *(Please Complete)*

School Name: \_\_\_\_\_

Estimated 2010-2011 School Enrollment: \_\_\_\_\_ *(Number of students)*

Voluntary Plan Flyer preferred delivery date *(when someone can sign for delivery)*: \_\_\_\_\_

Physical address for shipping: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

***Please include a copy of this voluntary rates page with your completed application by mail to  
UnitedHealthcare StudentResources  
Attn: K12 Sales  
P.O. Box 42299  
St. Petersburg, FL 33742-9936.***

