SCHOLAR/STUDENT/OBSERVER & DEPENDENT ENROLLMENT FORM

Questions? Call (800) 853-5899.

YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM

UNITED HEALTHCARE #__________________________

LAST (FAMILY) NAME ____________________________

FIRST NAME ____________________________

UM ID # ____________________________ DATE OF BIRTH No. Day Year

(Please use your "C" number)

U.S. MAILING ADDRESS

City State Zip

Phone # ____________________________ E-MAIL ADDRESS ____________________________

FEMALE MALE SINGLE MARRIED/DOMESTIC PARTNER

Check Status:

J-1 Visiting Scholar F-1 OPT Student J-1 Academic Training Student Observer

VISA TYPE (F-1, J-1, ETC.): ____________________________ HOME COUNTRY ____________________________

LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY FOR PERSONS INSURED UNDER THIS PLAN.

Coverage must be purchased at the time of the primary insured’s enrollment or within 30 days of termination of similar other coverage, or because of any of the following qualifying events: birth/marriage/legal or placement for adoption, legal guardianship or court or administrative order.

SPOUSE/SAME SEX DOMESTIC PARTNER

CHILD

CHILD

CHILD

CHILD

CHILD

EMERGENCY CONTACT PERSON

NAME ____________________________ RELATIONSHIP ____________________________ PHONE NUMBER ____________________________

E-MAIL ADDRESS ____________________________

NOTICE TO SCHOLAR/STUDENT/OBSERVER:

By signing, the scholar/student/observer 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;
3) He/She meets the eligibility requirements for this coverage as described in the brochure;
4) If it is later determined that the scholar/student/observer is not eligible, the premium will be refunded;
5) Policy renewal is the responsibility of the scholar/student/observer/dependent and must be requested prior to the termination of the current policy to prevent a lapse in coverage.

Questions? Call (800) 853-5899.

Please see other side for rates and payment information.
Enrollments will not be processed prior to the enrollment start date. Please submit your form or call to enroll during the enrollment period.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Quarterly 8/15/13 - 8/14/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Start Date</td>
<td>7/1/13</td>
</tr>
<tr>
<td>Scholar/Student/Observer (All ages)</td>
<td>$ 571</td>
</tr>
</tbody>
</table>

Dependent coverage is in addition to scholar/student/observer coverage and should be purchased for the same term of insurance as the scholar/student/observer’s plan.

<table>
<thead>
<tr>
<th>Dependent Coverage</th>
<th>Quarterly 8/15/13 - 8/14/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Same Sex Domestic Partner (Under 25 years of Age)</td>
<td>$ 1,463</td>
</tr>
<tr>
<td>Spouse/Same Sex Domestic Partner (Ages 25-34)</td>
<td>$ 1,682</td>
</tr>
<tr>
<td>Spouse/Same Sex Domestic Partner (Ages 35-44)</td>
<td>$ 2,275</td>
</tr>
<tr>
<td>Spouse/Same Sex Domestic Partner (Ages 45 and Over)</td>
<td>$ 2,613</td>
</tr>
<tr>
<td>Per Child</td>
<td>$ 584</td>
</tr>
</tbody>
</table>

Effective Date of Coverage: ___________________________
(Earliest Effective Date is 8/15/13 - All Coverage Terminates on 8/14/14)

Period of Coverage: # ________ Quarters

Payment Method (Premium is NON-REFUNDABLE):
- Check/Money Order payable to Wells Fargo (US funds only. Coverage will be cancelled and a $25.00 fee will be assessed for insufficient funds.)
- Credit Card: □ Visa □ Master Card

Account No. ________________ Expires: ________________
Cardholder’s Name: ____________________

Enroll by phone (800) 853-5899 or send enrollment form and payment by mail or fax: Wells Fargo Insurance Services, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670, Fax (877) 612-7966

This is limited term coverage only. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated. Coverage begins at 12:01 am and ends at midnight. 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 or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Complete both sides of the enrollment form and sign below.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements and I have read and understand the Plan Brochure. My signature below authorizes The University of Miami to provide Wells Fargo Insurance Services USA, Inc. with required information necessary to validate my enrollment. I understand my information is protected by privacy laws and will be released only in accordance with these laws.

Signature of Scholar/Student/Obs/ □ Dependent: ____________________ Date __________