



United HealthCare Insurance Company of New York
 P.O. Box 1500 Kingston NY 12402-1000

**HEALTH INSURANCE APPLICATION
 3-Month Extended Dependent Student Coverage**

To be completed and signed by Enrollee

Enrollee's Last Name	First	M.I.	Dependent Student's Name		
Street Address			Dependent Student's Social Security Number		
City	State	Zip Code	Dependent Student's Date of Birth		
Enrollee's Social Security Number			Date Student's Course Work Completed		
Daytime Telephone Number ()			School's Name		
I certify that the information I have given is true and correct and that this dependent is currently covered under the Empire Plan. Signature _____ Date ____/____/____ Enrollee's			School's Street Address		
			City	State	Zip Code
			School's Telephone Number ()		

RETURN TO:

Newburgh Enlarged City School District
 124 Grand Street
 Newburgh, NY 12550
 Attn: Health Benefits