

**UNIVERSITY OF THE INCARNATE WORD 2009-2010**

**INTERNATIONAL STUDENTS' DEPENDENTS ACCIDENT & SICKNESS INSURANCE ENROLLMENT FORM**

COLUMBIAN LIFE INSURANCE COMPANY • Home Office: Chicago, IL • Administrative Service Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381  
 COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • Home Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381

Student's Name \_\_\_\_\_ Soc. Sec. #    -   -      
(Please Print) (Last) (First) (MI)

Address \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_  
(Street) (City) (State) (Zip)

UnderGraduate  Graduate Birthdate \_\_\_\_\_ email \_\_\_\_\_  
(MM/DD/YY)

Health Professional Student - \$10 premium for Needle Stick Coverage (Refer questions to the Student Health Service)

Enclosed is my check or money order, payable to Student Assurance Services, Inc., in the amount of \$ \_\_\_\_\_ .  
 Mail to: Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082-0196.

**PREMIUM SCHEDULE : Please check the box of premium selected.**

	<b>ANNUAL</b>	<b>FALL TERM</b>	<b>SPRING/SUMMER TERM</b>	<b>SUMMER TERM</b>
	<b>08-01-2009 to 07-31-2010</b>	<b>08-01-2009 to 12-31-2009</b>	<b>01-01-2010 to 07-31-2010</b>	<b>05-01-2010 to 07-31-2010</b>
Student Only*	<input type="checkbox"/> \$ 697	<input type="checkbox"/> \$ 293	<input type="checkbox"/> \$ 404	<input type="checkbox"/> \$ 173
Spouse	<input type="checkbox"/> \$ 2,365	<input type="checkbox"/> \$ 1,000	<input type="checkbox"/> \$ 1,380	<input type="checkbox"/> \$ 595
Each Child	<input type="checkbox"/> \$ 1,680	<input type="checkbox"/> \$ 712	<input type="checkbox"/> \$ 983	<input type="checkbox"/> \$ 424

\*The above premium includes an administrative fee charged by the University.

Coverage becomes effective on the later of: the Policy Effective Date (08-01-2009); the first day of the term for which the proper premium has been paid; or 12:01 a.m. following the date the proper premium is received by the Plan Administrator or University. All coverage expires on 07-31-2010, or when payment is due and unpaid. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master policy. Any refunds will be subject to a \$25 administrative fee.

**DEPENDENT COVERAGE (complete if purchasing dependent coverage)**

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Soc. Sec. # MM/DD/YY

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Soc. Sec. # MM/DD/YY

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Soc. Sec. # MM/DD/YY

Student Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**This plan has an enrollment period; refer to the brochure that accompanies this Enrollment Form.**