

ENROLLMENT FORM

Please read instructions on page _____ carefully and print all information legibly.

Student's Name: _____
(First) (M.I.) (Last)

Billing Address:

(Street Address) (Apt. #)

(City, State, ZIP)

(Phone Number)

(Email Address)

Date of Birth: _____ Age: _____ Sex: _____
(Month/Day/Year)

Social Security Number: _____

Beneficiary: _____

Name of College or University: _____

City: _____ State: _____

Who Are You Enrolling?

- Student Only
- Student & Spouse
- Student & Child(ren)
- Student & Family

Dependent Information:

(Spouses' or Child's name) (Social Security Number) (Date of Birth)

(Child's name) (Social Security Number) (Date of Birth)

(Child's name) (Social Security Number) (Date of Birth)

(Child's name) (Social Security Number) (Date of Birth)

What Benefit Plan Are You Applying For?

- Plan I
- Plan II
- Plan III

Coverage Start Date: _____
(Month/Year)

Number of Months Being Paid For: _____

Premium Due: \$ _____

Is anyone proposed for coverage covered by any Title XIX program (such as, Medicaid)? Yes No

If yes, list names who will be excluded from coverage.

I verify that I am a registered Student of the above named school and I understand that my eligibility may be subject to verification by the school.

Signature: _____ Date: _____