

HOWARD UNIVERSITY
2009 – 2010 Injury and Sickness Plan A
DEPENDENT ENROLLMENT FORM

I am a student at Howard University and am enrolled in the Injury and Sickness coverage under the University's student insurance plan. I also elect to enroll my dependents as indicated below. Eligible dependents are spouse and unmarried children to age 19, (25 if full time students).

Please Check All Appropriate Boxes:

Insured Category: Domestic or F-1 International J-1 International

<u>Dependents of DOMESTIC Students and F-1 Visa Students:</u>	Annual 8/1/09-7/31/10	First / Semi-Annual 8/1/09-12/31/09	Second / Semi-Annual 1/1/10-7/31/10
Spouse	<input type="checkbox"/> \$1,947	<input type="checkbox"/> \$ 974	<input type="checkbox"/> \$ 974
Children	<input type="checkbox"/> \$ 566	<input type="checkbox"/> \$ 283	<input type="checkbox"/> \$ 283
Spouse & Children	<input type="checkbox"/> \$2,513	<input type="checkbox"/> \$1,257	<input type="checkbox"/> \$1,257

<u>Dependents of J-1 Visa Students:</u>	Annual 8/1/09-7/31/10	First / Semi-Annual 8/1/09-12/31/09	Second / Semi-Annual 1/1/10-7/31/10
Spouse	<input type="checkbox"/> \$2,807	<input type="checkbox"/> \$1,404	<input type="checkbox"/> \$1,404
Children	<input type="checkbox"/> \$ 819	<input type="checkbox"/> \$ 409	<input type="checkbox"/> \$ 409
Spouse & Children	<input type="checkbox"/> \$3,626	<input type="checkbox"/> \$1,813	<input type="checkbox"/> \$1,813

STUDENT INFORMATION: Primary Insured Student Name: _____
First Name Middle Initial Last Name

Student Social Security Number _____ Student School ID Number: _____

Student Gender: Male Female Student Date of Birth: _____ - _____ - _____
Month Day Year

Mailing Address: _____
Number and Street

_____ City _____ State _____ Zip Code _____

Telephone Number: (_____) _____ E-mail address: _____

To enroll dependents, list dependents to be insured below. Dependent coverage is available only if the student is also enrolled in this plan.

<u>Last Name</u>	<u>First Name</u>	<u>MI</u>	<u>Date of Birth</u>	<u>Social Security Number</u>
Spouse: _____				
Child: _____				
Child: _____				

Notice to Student: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) he/she has carefully read the brochure and elects to enroll dependents as indicated on this enrollment form; 2) rates are not pro-rated other than as listed on this enrollment card; 3) dependents meet the eligibility requirements of this coverage as described in the brochure; and 4) if it is later determined that the dependents are not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

Student Signature: _____ **Date:** _____

Enrollment & Payment Procedure:
 Mail this enrollment form with payment in US dollars to Summit America Insurance Services, LC. 7400 College Blvd., Suite 100, Overland Park, KS 66210. Make check or money order payable to Summit America Insurance Services. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payment. Renewal notices will not be sent for re-enrollment. To charge your premium to American Express, Visa or Master Card, complete the charge card authorization below.
Note: We cannot accept payment by phone.

Credit Card Authorization	
AmEX / Visa / MasterCard # _____	Exp Date: _____ / _____ Charge Amount \$ _____
Print Name of Cardholder: _____	Signature: _____