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ENROLLMENT FORM INTERNATIONAL POST-DOCTORAL FELLOWS AND VISITING SCHOLARS

FLORIDA STATE UNIVERSITY

2015-641-4

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR PURCHASER.		
SOCIAL SECURITY #:	OR PURCHASER ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	
PERMANENT U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)		
CITY:	STATE:	ZIP CODE:
TELEPHONE #:	EMAIL ADDRESS:	

DEPENDENT INFORMATION

Complete information below for Dependents to be insured. Dependent coverage is only available for Purchasers insured under the Plan (Please include a blank sheet for additional Dependents).

SPOUSE SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:
CHILD SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)
First (Given) Name:	Middle Initial:	Last (Family) Name:

NOTICE TO PURCHASER: 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 purchaser acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the purchaser is not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false incomplete, or misleading information is guilty of a felony of the third degree.

Purchaser's Signature: ______________________________ Date: ______________

Campus/School Attending: **Florida State University**

☐ **I elect to purchase Injury and Sickness insurance coverage under the University's purchaser insurance plan. Below are the choices I have made.**

PLEASE CHECK ALL APPROPRIATE BOXES.

INSURED CATEGORY: ☐ **Fellows - Post-Doctoral** ☐ **Visiting Faculty/Scholars** ☐ **Center for Intensive English Studies (CIES)**

ID Codes		Annual (A-)	Monthly (MX)
1	Purchaser	☐ $ 2,150.00	☐ $ 179.00
2	Spouse	☐ $ 2,150.00	☐ $ 179.00
3	Each Child	☐ $ 2,150.00	☐ $ 179.00
4	All Children	☐ $ 4,300.00	☐ $ 358.00

NOTE: The amounts stated above include certain fees charged by the school you are receiving coverage through. Such fees include amounts which may be paid to certain non-insurer vendors or consultants by, or at the direction of, your school.

EFFECTIVE/EXPIRATION PERIODS:

☐ Annual 8/15/2015 to 8/14/2016

EFFECTIVE AND TERMINATION DATES:

Coverage will become effective on the date the authorized representative receives the application and correct premium payment.

Annual coverage expires 1 year following receipt of your premium or August 14, 2016, whichever is earlier. Monthly coverage expires 1 month following receipt of your premium or August 14, 2016, whichever is earlier.

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received. **Requested Effective Date:** _____/_____/_____.

Attach copy of appointment letter or other document showing when coverage must begin. THIS IS REQUIRED.

TO CALCULATE YOUR RATE:

Rate x # of months eligible = amount due Example: $179.00 x 3 months = $537.00

Deliver completed application to Health Compliance, room 1005, of the Wellness Center. The premium will be placed on your account and must be paid in full at time of purchase.