

Florida State University 2009 – 2010
Post Doctoral Fellow and Visiting Scholar Medical Insurance Plan Application (Please Print)

Applicant's Name (Last, First, Middle)		Date of Birth (mmddyy)	
Permanent U.S. Address (Street, City, State, Zip)		International Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Phone #: ()	Social Security # / International Applicants use FSUSN (student #)	
Effective Date:	Termination Date:	Visiting Scholar: <input type="checkbox"/> Yes <input type="checkbox"/> No	Post Doctoral Fellow: <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent coverage is available only if the visiting scholar or post doctoral fellow is insured under one of these plans and the coverage periods must be the same.

List below dependents to be insured.

	Last Name	First Name	Social Security # (International Applicants use FSUSN)	Male/ Female	Date of Birth (mmddyy)
Spouse					
Child					
Child					
Child					

Premium Rates *Please check all appropriate boxes. One month minimum purchase required.*

This chart demonstrates the monthly rates. In order to accurately calculate your total premium due please contact CRM prior to submitting the application and payment.	Monthly Rate Domestic Base Plan	Monthly Rate Domestic Comprehensive Plan	Monthly Rate International Comprehensive Plan
	Applicant	<input type="checkbox"/> \$77	<input type="checkbox"/> \$104
Spouse	<input type="checkbox"/> \$199	<input type="checkbox"/> \$246	<input type="checkbox"/> \$302
Child	<input type="checkbox"/> \$98	<input type="checkbox"/> \$132	<input type="checkbox"/> \$140
Children	<input type="checkbox"/> \$156	<input type="checkbox"/> \$210	<input type="checkbox"/> \$226

Payment Instructions: Make check or money order payable to Collegiate Risk Management in US dollars. **Mail payment to: Collegiate Risk Management, P.O. Box 850001, Orlando, FL 32885-0184.** Your canceled check is your only receipt. It is the Applicant's responsibility for timely renewal payments whether or not a renewal notice is received. If you have questions please contact Collegiate Risk Management at 1-800-922-3420. When paying with a credit/debit card please apply online at www.collegiaterisk.com.

Notice to Applicants: By signing below, the Applicant acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this application; 2) I understand that my Benefit Booklet will only be made available online at www.collegiaterisk.com. At any time, I may request paper copies of these materials be mailed to me by contacting BCBSF's Customer Service Department at 800-664-5295. My signature on this application affirms my understanding that the Benefit Booklet will not be mailed to me, unless I contact BCBSF's Customer Service Department and request to opt out of electronic receipt; 3) Rates are not pro-rated other than as listed on this application; 4) He/She meets the eligibility requirements for this coverage as described in the brochure; 5) If it is later determined that the applicant is not eligible, the payment will be refunded; and 6) Other than eligibility, the payment is not refundable.

Signature of Applicant _____ Date _____