DEPENDENT MEDICAL INSURANCE ENROLLMENT FORM 2009 – 20010

This enrollment form is ONLY FOR DEPENDENTS of students/scholars currently insured in the health insurance plan for the State University of New York

Dependent coverage is available at the time the student is enrolled or within 31 days of marriage, birth, or arrival in the U.S.

Student Information

Last Name ____________________ First Name ____________________

SUNY Campus ____________________ Student ID or Social Security # ____________________

Home Country ____

U.S. Mailing Address ____

City, State, Zip ____

Telephone ____________________ Email ____________________

Birth Date: (mm/dd/yyyy) ____________________ ☐ Female ☐ Male ☐ Student ☐ Scholar

Dependent Information

Name of Dependents: Date of Birth (mm/dd/yyyy)

Spouse ____________________ ____________________ ☐ Female ☐ Male

Child ____________________ ____________________ ☐ Female ☐ Male

Child ____________________ ____________________ ☐ Female ☐ Male

Child ____________________ ____________________ ☐ Female ☐ Male

	Period of Coverage	Spouse	Children	Total
Annual	8/15/09 to 8/14/10	☐ $2,136	☐ $1,152	
Quarterly	8/15/09 to 11/14/09	☐ $534	☐ $288	
	11/15/09 to 2/14/10	☐ $534	☐ $288	
	2/15/10 to 5/14/10	☐ $534	☐ $288	
	5/15/10 to 8/14/10	☐ $534	☐ $288	
Monthly* (or fraction of)		☐ $178	☐ $96	

Begin Coverage on ___/___/___ and continue for ___ months | Monthly premium $________ x # of months______ = _______

* Available only when a term of less than three months is required, or in order to provide coverage for dependents arriving prior to the beginning of a term. Coverage cannot extend past 8/14/10.

Make checks payable to ***HTH Worldwide Insurance Services*** and mail with enrollment form to HTH Worldwide Insurance Services, One Radnor Corporate Center, Suite 100, Radnor, PA 19087. REMITTANCE IN U.S. FUNDS ONLY.

I understand that expenses incurred by my dependents for conditions for which they receive treatment for medical advice, or had symptoms, prior to effective date of coverage, may not be covered until they have been enrolled in the plan for 6 continuous months.

Signature of Student ________________________________ Date ____________

Reminder for Dependents: Please enclose a photocopy of your I-94. This is required by the Insurance Company

Verification: I verify that the above applicant(s) is/are dependent(s) of ________________________

an international student duly enrolled in the SUNY International Student & Scholar Insurance Program.

Verified by: (name & title, i.e. FSA) ________________________ Date ____________