

HEALTH INSURANCE ENROLLMENT FORM DEPENDENTS OF J-VISA EMPLOYEES OF SUNY OR RESEARCH FOUNDATION 2009 – 2010

PLEASE PRINT – ANSWER ALL QUESTIONS – USE BLACK OR BLUE INK

Employee's Last Name: _____ Employee's First Name: _____

Campus Affiliation: _____
Name of SUNY School

- | | | |
|--|---|--|
| <input type="checkbox"/> SUNY | <input type="checkbox"/> International Employee | If international Visa Type: <input type="checkbox"/> J-1 |
| <input type="checkbox"/> Research Foundation | <input type="checkbox"/> American Employee Traveling Abroad | <input type="checkbox"/> F-1 |

USA Street Address: _____ Email : _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Male Female Date of Birth: MM/DD/YYYY Home Country: _____

Current Insurance ID Number: _____ Student ID or Social Security # : _____

PREMIUM RATES

IMPORTANT – DEPENDENT COVERAGE IS AVAILABLE ONLY WHEN THE STUDENT FIRST ENROLLS IN THIS INSURANCE PLAN OR WITHIN 31 DAYS OF BIRTH, MARRIAGE OR ARRIVAL IN THE USA.

Premium rates for dependents of employees of SUNY or Research Foundation are listed below. These rates are 25% of the total premium. Make your check payable to HTH Worldwide Insurance Services and mail with this form to the address below.

Term	Spouse	Child(ren)
<input type="checkbox"/> 8/15/09 – 8/14/10 (Annual)	\$534.00	\$288.00
<input type="checkbox"/> 8/15/09 – 1/14/10 (Fall)	\$222.50	\$120.00
<input type="checkbox"/> 1/15/10 – 8/14/10(Spring/Summer)	\$311.50	\$168.00
<input type="checkbox"/> 5/15/10 – 8/14/10(Summer Only)	\$133.50	\$ 72.00
<input type="checkbox"/> Monthly (or Fraction of)*	\$ 44.50	\$ 24.00

* Monthly rate available only when a term of less than 3 months is required or in order to cover dependents arriving before the beginning of a term.

DEPENDENT INFORMATION (If Enrolled)

	Last Name	First Name	Date of Birth	Male	Female
Spouse:	_____	_____	<u>MM/DD/YYYY</u>	<input type="checkbox"/>	<input type="checkbox"/>
Child:	_____	_____	<u>MM/DD/YYYY</u>	<input type="checkbox"/>	<input type="checkbox"/>
Child:	_____	_____	<u>MM/DD/YYYY</u>	<input type="checkbox"/>	<input type="checkbox"/>
Child	_____	_____	<u>MM/DD/YYYY</u>	<input type="checkbox"/>	<input type="checkbox"/>
Child	_____	_____	<u>MM/DD/YYYY</u>	<input type="checkbox"/>	<input type="checkbox"/>

PREMIUM CALCULATION

Spouse	\$ _____
Child(ren)	\$ _____
Total Due	\$ _____

Make check payable to:
HTH Worldwide Insurance Services

and mail with this form to:

HTH Worldwide Insurance Services

One Radnor Corporate Center, Suite 100
Radnor, PA 19087

REMITTANCE IN U.S. FUNDS ONLY

I wish to enroll for insurance under the terms of the Policy for the period beginning _____/_____/_____ and extending for _____ months.

Student's Signature and Date

Advisor's Authorization