DOMINICAN UNIVERSITY
2009-2010 STUDENT ACCIDENT & SICKNESS INSURANCE ENROLLMENT FORM

☒ **COLUMBIAN LIFE INSURANCE COMPANY** • Home Office: Chicago, IL • Administrative Service Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381
❒ **COLUMBIAN MUTUAL LIFE INSURANCE COMPANY** • Home Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381

To apply for Student Accident and Sickness Insurance, either complete this enrollment form or enroll on-line at: www.dominicaninsurance.com

☐ Undergraduate ☐ Graduate ☐ International Student ID: _____ Credit Hours _____

Student's Name _____ Soc. Sec. # ☐☐☐ - ☐☐ - ☐☐☐☐
(Please Print) (Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Birthdate _____ Telephone _____ email: _____
(MM/DD/YY)

☐ NO: I have comparable insurance coverage and waive my right to participate in the University's Student Accident and Sickness insurance plan. I accept responsibility for any medical expense I incur while attending the University.

☐ YES: I wish to purchase the Student Accident and Sickness Insurance plan.

PREMIUM SCHEDULE (INDICATE PREMIUM SELECTED)

	ANNUAL	FALL	SPRING	SPRING/SUMMER	SUMMER	**QUARTERLY	**MONTHLY
	09-01-2009 to 08-31-2010	09-01-2009 to 12-31-2009	01-01-2010 to 05-31-2010	01-01-2010 to 08-31-2010	06-01-2010 to 08-31-2010	09-01-2009 to 11-30-2009 12-01-2009 to 02-28-2010 03-01-2010 to 05-31-2010 06-01-2010 to 08-31-2010	
Student	❒$ 1,494.00	❒$ 608.00	❒$ 608.00	❒$ 1,011.00	❒$ 414.00	❒$ 414.00	❒$ 135.00
Spouse	❒$ 2,981.00	❒$ 1,193.00	❒$ 1,193.00	❒$ 1,938.00	❒$ 805.00	❒$ 805.00	❒$ 259.00
Each Child	❒$ 2,234.00	❒$ 894.00	❒$ 894.00	❒$ 1,497.00	❒$ 604.00	❒$ 604.00	❒$ 197.00

***** A $10 administrative fee has been added to all student rates except Annual.
****** Quarterly and monthly premium is available only if purchasing Annual coverage with an automatic debit from your checking, savings or credit card account. Complete the automatic debit authorization on the reverse side of this form.

Coverage becomes effective on the later of the following dates: the Policy Effective Date (09-01-2009) at 12:01 a.m.; the first day of the term for which the proper premium has been paid; or 12:01 a.m. following the date the proper premium is received by the Servicing Agent. All coverage expires on the earliest of the following dates: the last day of the Coverage period for which the premium is paid; or when payment for your health insurance coverage is due and unpaid; or Policy expiration date 08-31-2010 at 11:59 p.m. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master policy.

DEPENDENT INFORMATION (COMPLETE IF PURCHASING DEPENDENT COVERAGE)

Spouse's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # MM/DD/YY

☐ Enclosed is my check or money order, payable to Student Health Insurance, Inc., in the amount of $ _____.
Mail to: Associated Insurance Plans International, Inc. P.O. Box 189 Libertyville, IL 60048

☐ Please charge my credit card a one-time premium payment of $_____. Complete credit card information below.

☐ Please automatically charge my credit card the following Quarterly or Monthly premium for the entire policy year: $_____.
Complete the credit card information below and sign the Automatic Payment Authorization on the reverse side of this form to activate this payment method.

Check credit card type: ☐VISA® ☐MasterCard® or ☐Discover®

Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Security Code (on back of card, 3 digits) ☐☐☐

Card Expiration Date (Month) (Year) ☐☐ - ☐☐

Credit card billing will state: "Student Insurance Plan"

Cardholder Name/Cardholder Signature _____ Date ___/___/___
(Phone No.) (MM/DD/YY)

Cardholder Address _____
(Street) (City) (State) (Zip)

I understand the policy excludes benefits for a Pre-Existing Condition, not subject to Credit for Prior Coverage, until I am continuously covered under the policy for 12 months.

Student Signature _____ Date ___/___/___

AUTOMATIC PAYMENT WITHDRAWAL FORM (Checking or Savings Account)

☐ Please automatically withdraw payment from my Checking or Savings account for the following Quarterly or Monthly premium for the entire policy year:

$_____ Must sign the Automatic Payment Authorization below to activate this payment method.

NOTE: Automatic payment from your checking account requires copy of a voided check; mail the voided check to Student Insurance Plan, Associated Insurance Plans International, Inc. P.O. Box 189, Libertyville, IL 60048.

Financial Institution: _____ Address: _____

Name of Bank Account Owner: _____ _____

Frequency: ( ) Monthly ( ) Qurarterly

Account Type: ( ) Checking or ( ) Savings

Routing Number: ☐☐☐☐☐☐☐☐☐ must have 9 digits in routing #

Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Can have up to 17 positions in account #

Attach a voided check, coded deposit slip if available

Automatic Payment Authorization

I authorize the payment of debits drawn on my checking, savings, or credit card account payable to Columbian Life Insurance Company and/or its designee ("the Company") , provided there are sufficient funds in the account. I agree that the Company shall be under no liability whatsoever in the event of one or more dishonored debits, whether any alleged harm or damage is directly or indirectly the result of the dishonor, and whether the dishonor results in the forfeiture of insurance or any other harm or damage.

I hereby waive any requirement for giving notice of premiums due as long as this Authorization is in effect. No premium shall be deemed to have been paid until the Company receives the actual payment which is not subsequently reversed. The use of this Plan shall in no way change the provisions of the policy with respect to the termination of such Policy upon nonpayment of the premium due.

This Authorization shall remain in effect until August 31, 2010, or until terminated by me upon a thirty day written notice to the Company. The Company may terminate the Automatic payment plan if any banking or credit card fund transfer is not paid on presentation. Upon termination, premiums due under the Policy shall be payable directly to the Company.

For Quarterly premiums, your account will be debited on December 1, 2009, March 1, 2010 and June 1, 2010. For Monthly premiums, your account will be debited on the 1st of each month through August 1, 2010.

_____ _____

Authorized Signature as it appears on Bank Records or Credit Card Date