DOMINICAN UNIVERSITY • ACCIDENT AND SICKNESS CARD COMPANION LIFE INSURANCE COMPANY 2013-2014

Please Print Legibly

Student's Name ______________________________________
(First) (M) (Last)

Student I.D. # ______________________________________

Billing Address:
Street______________________________ **Apt. No.** ________

City______________________**State** _____ **Zip** __________

☐ **Male** ☐ **Female** **Date of Birth** ____________________

Telephone No. ______________________________________

E-mail Address (IMPORTANT!) ___________________________

Do you have any other medical insurance? ☐ **YES** ☐ **NO.**

If yes, name of insurance company:_______________________

Spouse's Name_______________________________________

Date of Birth (mm/dd/yy) _______________________________

Social Security #_____________________________________

Child_______________ **Date of Birth (mm/dd/yy)** __________

Social Security #_____________________________________

Child_______________ **Date of Birth (mm/dd/yy)** __________

Social Security #_____________________________________

☐ **I do not wish to participate and hereby waive all student health insurance benefits.**

☐ **I wish to enroll in the Student Insurance Plan checked below.** My check or money order for the amount shown is attached.

Make check or money order payable to **Student Insurance Plan.**
Mail this enrollment card along with premium to:
Post Office Box 189, Libertyville, IL 60048

☐ **I wish to have my student account charged for the insurance term selected below.**

	Annual	**Fall Only**
Student Only	☐ $1,585	☐ $ 803
Additional for Spouse	☐ $3,273	☐ $1,647
Additional for each Child	☐ $2,320	☐ $1,170

	Spring & Summer	**New Summer**	**Monthly**
Student Only	☐ $ 803	☐ $487	☐ $142
Additional for Spouse	☐ $1,647	☐ $982	☐ $283
Additional for each Child	☐ $1,170	☐ $696	☐ $203

Note: For term date, see page 5, Periods of Coverage.

*Monthly premium is available for ANNUAL coverage. Premium will be debited on the 23rd of each month through July 23, 2014. Your signature below indicates that you are aware that your are purchasing ANNUAL coverage with a MONTHLY automatic payment using your banking or credit account. If you do not desire annual coverage, please select another term of coverage.

*MONTHLY ENROLLEES...Please indicate which month you desire your coverage to begin ___________(Month). Initial payment is due upon enrollment. Please complete Automatic Payment Authorization Form.

☐ **Please charge my Student Health Insurance:** **Coverage is not automatic.**

You must re-enroll in the insurance plan each term.

☐ STUDENT ACCOUNT ☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

Credit//Debit Card Number ____________________________

3 or 4 digit security code _______ **Expiration Date** ___________

Print name of cardholder ______________________________

Cardholder signature _________________________________

Please Charge $___________ **for Student Health Insurance.**

Student signature ____________________________________

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at **www.DominicanInsurance.com**

DOMINICAN UNIVERSITY • STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2013-2014

☐ I request and authorize COMPANION LIFE INSURANCE COMPANY and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. **This Authorization will remain in effect until the end of the policy year.** I understand that a new authorization form must be completed each policy year.

DRAFT DATE: __________ **(Will be debited on the 23rd of each month, through July 23, 2014)** **DRAFT AMOUNT:**__________

Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

ADDRESS OF BANK

CITY **STATE** **ZIP**

NAME OF INSURED, APPLICANT (PRINT)

NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED

DEPOSITOR SOCIAL SECURITY NUMBER

DEPOSITOR DRIVER'S LICENSE NUMBER

DEPOSITOR STATE

RELATIONSHIP TO INSURED

SIGNATURE OF DEPOSITOR **DATE**

PLEASE AUTOMATICALLY CHARGE MY STUDENT INSURANCE PREMIUMS TO THE ACCOUNT IDENTIFIED BELOW FOR THIS ENTIRE POLICY YEAR.

☐ **STUDENT ACCOUNT AT MY SCHOOL**

☐ **BANK CHECKING ACCOUNT (REQUIRES A COPY OF A VOIDED CHECK-DO NOT SEND DEPOSIT SLIP)**

☐ **CREDIT CARD ACCOUNT (2.5% CONVENIENCE FEE IS ADDED TO PREMIUM CHARGED)** ☐ **VISA** ☐ **DISCOVER** ☐ **MASTERCARD** ☐ **AMERICAN EXPRESS**

Credit/Debit
Card Number________________________ **Expires:**_______

Last 3 numbers on the reverse side of the credit card. Located within the signature box _____ ***(For Authorization Purposes)***

Print name of cardholder ______________________________

Cardholder phone number ______________________________

Amount authorized to debit______**for Student Health Insurance.**

Cardholder signature__________________________________
Today's Date

FOR HOME OFFICE USE ONLY
BANK TRANSIT NUMBER ____________________
DEPOSITOR'S ACCOUNT NUMBER ____________________