SAINT XAVIER UNIVERSITY
AUTOMATIC PAYMENT AUTHORIZATION 2014-2015

☐ **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. I understand that there is no provision for cancellation unless admitted into the Armed Forces.**

DRAFT DATE: _____ (Will be debited on the 11th of each month)

DRAFT AMOUNT:_____

Check One: ☐ Checking Account ☐ Savings Account

_____
NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

_____
ADDRESS OF BANK

_____
CITY STATE

_____
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

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT
REQUIRES A COPY OF A VOIDED CHECK
(PLEASE DO NOT SEND A DEPOSIT SLIP)

☐ ***Please automatically charge my Student insurance premiums to my account identified below for this entire policy year.***

☐ VISA ☐ DISCOVER ☐ MASTERCARD ☐ AMEX

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 _____

SAINT XAVIER UNIVERSITY
ACCIDENT AND SICKNESS CARD 2014-2015
COMPANION LIFE INSURANCE COMPANY

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 Semester Installment
Student Only	☐ $1,667	☐ $ 695
Additional for Spouse	☐ $3,003	☐ $1,252
Additional for each Child	☐ $2,497	☐ $1,041
	Spring & Summer Semester Installment	**New Students Spring & Summer**
Student Only	☐ $ 972	☐ $1,298
Additional for Spouse	☐ $1,751	☐ $2,301
Additional for each Child	☐ $1,456	☐ $1,920
	New Students Summer	*Monthly
Graduate Student Only	☐ $ 559	☐ $ 139
Additional for Spouse	☐ $ 893	☐ $ 250
Additional for each Child	☐ $ 766	☐ $ 208

Note: For term date, see page 4, Periods of Coverage.

*Monthly premium is available for ANNUAL coverage. Premium will be debited on the 11th of each month through July 11, 2015. 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.SaintXavierInsurance.com**