OPTIONAL, ADDITIONAL PREMIUM DENTAL AND VISION *INSURANCE PLAN*

(Additional premium required)

Underwritten by Security Life Insurance Company of America

- **Freedom to Use Dentist of Your Choice**
- **Up to $2,000 Annual Maximum**
- **Coverage for Adult Sealants**
- **Six Plan Design Options**
- **No Waiting Periods for Most Services**
- **Coverage for Orthodontics**
- **Optional Vision Coverage for Additional Premium**

Review the plan options and enroll at **www.DominicanInsurance.com**. You do not need to be enrolled in the health insurance program to obtain Dental and Vision coverage.

QUESTIONS? PLEASE CALL 800-452-5772.
You do not need to purchase health insurance to enroll in the optional dental and vision insurance plan. Enroll online at www.DominicanInsurance.com.

DOMINICAN 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 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	☐ $1,850	☐ $ 925
Additional for Spouse	☐ $3,794	☐ $1,897
Additional for each Child	☐ $2,692	☐ $1,346

	Spring & Summer	New Summer	Monthly
Student Only	☐ $1,175	☐ $748	☐ $165
Additional for Spouse	☐ $1,897	☐ $1,544	☐ $320
Additional for each Child	☐ $1,346	☐ $1,096	☐ $227

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, 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.DominicanInsurance.com**