ILLINOIS CENTRAL COLLEGE
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.ILCentralInsurance.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)

PREMIUM SCHEDULE (INDICATE PREMIUM SELECTED)

PREMIUMS	Annual 08-16-2009 to 08-15-2010	Spring/Summer 01-15-2010 to 08-15-2010	Summer 06-16-2010 to 08-15-2010	**Monthly
Student	❒ $ 653.00	❒ $ 436.00	❒ $ 215.00	❒ $ 76.00
Spouse	❒ $ 1,737.00	❒ $ 1,162.00	❒ $ 574.00	❒ $ 184.00
Spouse and Child(ren)	❒ $ 2,698.00	❒ $ 1,807.00	❒ $ 889.00	❒ $ 280.00
Child(ren)	❒ $ 961.00	❒ $ 642.00	❒ $ 317.00	❒ $ 107.00

* A $10 administrative fee has been added to all student rates except Annual.
** 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 (08-16-2009) 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 earlier of: 08-15-2010, or when payment for your Accident or Sickness coverage is due and unpaid. 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, 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 Monthly premium for the entire policy year: $_____.
Complete the Automatic Payment Authorization Form 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 Health Insurance"

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

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

Student Signature _____ Date ___/___/____

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AUTOMATIC PAYMENT WITHDRAWAL FORM (Credit Card, Checking or Savings Account)

☐ Please automatically charge my credit card the following monthly premium for the entire Policy Year $ _____.
Complete the credit card information and sign the Automatic Payment Authorization below to activate this payment method.

☐ Please automatically withdraw payment from my Checking or Savings account for the following Monthly premium for the entire policy year:
$_____ . Complete the bank account information and 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.

BANK ACCOUNT

Financial Institution: _____ Address: _____

Name of Bank Account Owner: _____ _____

Frequency: ( ) Monthly

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

CREDIT CARD ACCOUNT

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 Health Insurance"

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

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

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 15, 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 Monthly premiums, your account will be debited on the 16th of each month through July 16, 2010.

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