PROVIDENCE CHRISTIAN 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 Insurance coverage, complete this Enrollment Form and return it with your payment to: Student Insurance Plan, Associated Insurance Plans International, Inc., P.O. Box 189, Libertyville, IL 60048. List Dependents on the reverse side of this form. Soc. Sec. # Student's Name (First) (MI) (Please Print) (Last) Address Phone# (Street) (City) (State) (Zip) □ Undergraduate □ Graduate □ International Birthdate email MM/DD/YY Enclosed is my check or money order, payable to Student Health Insurance, Inc., in the amount of \$ to the following credit card: UVISA® DMasterCard® or Discover® ☐ Please charge \$ Card Expiration Date Credit card billing will state: Credit Card Number Security Code (on back of card, 3 digits) (Month) (Year) "Student Assurance Services, Inc." Cardholder Name/Cardholder Signature Date (Phone No.) Cardholder Address 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 6 months. Date Student Signature U-31MI/CA(enr) A276CFG PROVIDENCE CHRISTIAN 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 Insurance coverage, complete this Enrollment Form and return it with your payment to: Student Insurance Plan, Associated Insurance Plans International, Inc., P.O. Box 189, Libertyville, IL 60048. List Dependents on the reverse side of this form. Soc. Sec. Student's Name (MI) (Please Print) (First) (Last) Address Phone# (Street) (City) (State) (Zip) □ Undergraduate □ Graduate □ International Birthdate MM/DD/YY Enclosed is my check or money order, payable to Student Health Insurance, Inc., in the amount of \$ to the following credit card: UISA® MasterCard® or Discover® ☐ Please charge \$ Card Expiration Date Credit card billing will state: Credit Card Number Security Code (on back of card, 3 digits) (Month) (Year) "Student Assurance Services, Inc." Cardholder Name/Cardholder Signature Date (Phone No.) Cardholder Address I understand the policy excludes benefits for a Pre-Exisiting Condition, not subject to Credit for Prior Coverage, until I am continuously covered under the policy for 6 months. Student Signature Date MM DD A276CFG U-31MI/CA(enr) PROVIDENCE CHRISTIAN 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 Insurance coverage, complete this Enrollment Form and return it with your payment to: Student Insurance Plan, Associated Insurance Plans International, Inc., P.O. Box 189, Libertyville, IL 60048. List Dependents on the reverse side of this form. Student's Name Soc. Sec. # (Please Print) (Last) (First) (MI) Address Phone# (Street) (City) (State) (Zip) ☐ Undergraduate ☐ Graduate ☐ International Birthdate MM/DD/YY Enclosed is my check or money order, payable to Student Health Insurance, Inc., in the amount of \$ to the following credit card: UISA® DMasterCard® or Discover® ☐ Please charge \$ Card Expiration Date Credit card billing will state: Credit Card Number Security Code (on back of card, 3 digits) (Month) (Year) "Student Assurance Services, Inc." Cardholder Name/Cardholder Signature Date MM חח (Phone No.)

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 Date
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PREMIUM:

I have read the details concerning the College's Student Insurance Plan in the brochure provided. I understand the college requires that all students are automatically enrolled for the Basic Injury Benefits of the plan. But I also want to purchase the coverage I've indicated below:

> **Annual** 08-15-2009 to 08-14-2010

Student Only-Sickness & Major Medical Benefits Each Dependent -Injury, Sickness, & Major Medical

□ \$ 300

1 \$ 1,165

Dependents must enroll in the plan when the student first enrolls in the plan and enroll for the same coverage as the student. Your Rasic Injury Renefits

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becomes effective on Policy Effective Date (08-15-2009); or th first day of the term for which the premium has been paid. Your Basic Sickness and Major
Medical Genefits becomes effective on the later of: the Policy Effective Date (08-15-2009); 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 08-14-2010 or when
payment for your Accident and Sickness coverage is due and unpaid. 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
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Spouse's Name		Birthdate	
Child's Name	Soc. Sec.#	Birthdate	MM/DD/YY
Child Straine	Soc. Sec.#	birtildate	MM/DD/YY
Child's Name		Birthdate	
4070050	Soc. Sec.#		MM/DD/YY
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Child's Name		Birthdate	100000
Child's Name	Soc. Sec.#	Birthdate	MM/DD/YY
	Soc. Sec.#		MM/DD/YY
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