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

☐ Please automatically charge my credit card the following monthly premium for the entire **Spring/Summer** $ ______________.
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 **Spring/Summer**:
$_________________ . Complete the bank account information and sign the Automatic Payment Authorization below to activate this payment method.

Important: Please note there is no provision for cancellation of the automatic monthly debit payment option prior to the policy expiration date, other than upon a student's entry into the military service. Students interested in coverage for a term other than the Spring/Summer coverage should elect an optionforpayment other than monthly automatic debit.

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 #

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 ____ (Phone No.) Date ___/____/____ (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 21, 2010. 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 22nd of each month through July 22, 2010.

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

CREDIT FOR PRIOR COVERAGE

This plan provides portability of coverage as it relates to "pre-existing" health conditions:

a) If, at the time of enrollment, you have **not** been covered by Prior Creditable Coverage, this policy will not cover pre-existing conditions until you have continuous coverage for twelve (12) months under this policy.

b) If you were covered by Prior Creditable Coverage, the pre-existing conditions waiting period will be reduced by the period of time you were covered by prior creditable coverage. Coverage must be continuous and there must be no break in coverage 63 days or more immediately prior to your effective date of coverage under this Policy. To obtain credit for previous coverage, you must provide evidence of Prior Creditable Coverage within 30 days of enrollment in this policy.

EXCLUSIONS

The policy does not provide Benefits for expense resulting from:

1. Air flight, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline. **This exclusion will be waived for students enrolled in the Indiana State Aero Space Program while participating in the program.**
2. Dental treatment, except dental treatment made necessary by injury to natural teeth. Coverage for dental treatment for a newborn shall include, but not be limited to, treatment (including orthodontic and oral surgery) for the management of birth defects known as cleft lip and cleft palate.
3. Treatment where no Injury or Sickness is involved (physical examinations or preventive medicines); or Elective Surgery and Elective Treatment; or abortion. It does not include cosmetic surgery made necessary by Injury.
4. Motor Vehicle Accidents, to the extent covered by another valid and collectible insurance policy, prepaid services contract, or similar plan.
5. Eyeglasses, contact lenses, and examination for prescribing or fitting them; any other procedure for correction of refractive disorder of the eye or eyes; hearing aids and hearing examinations.
6. Injury or Sickness for which benefits are paid under Worker's Compensation or Occupational Disease Act or Law.
7. Injury sustained while participating in the practice or play of interscholastic sports or intercollegiate sports, including the participation in any practice or conditioning program for such sport, contest or competition.
8. Intentional self-inflicted Injuries; Loss incurred while committing or attempting to commit a felony; or Loss due to voluntary participation in a riot or civil disturbance.
9. Routine new-born baby care, well baby nursery and related Physician's charges, except as specifically provided in the Benefits Schedule.
10. Services provided normally without charge by the Health Service of the Policyholder; or by any person employed or retained by the Policyholder; or services covered or provided by the student health fee.
11. Use of any services or supplies which are not in accord with generally accepted standards of medical practice; organ transplants, including donor's expenses.
12. War or act of war, whether declared or not; and Injury or Sickness resulting from full-time, active-duty military service.
13. Pre-existing Conditions, not subject to Credit for Prior Coverage, until continuously covered by the Policyholder's Student Accident and Sickness Insurance plan for a period of 12 consecutive months.

DEFINITIONS

Copay means a fee that is the Insured's responsibility each time a covered service is received.

Deductible means an amount subtracted from Eligible Expenses, for each Injury or Sickness, before benefits are considered.

Elective Surgery and Elective Treatment means surgery or medical treatment which is not necessitated by a pathological change occurring after your Effective Date of coverage. Elective Sur-

gery includes but is not limited to: tubal ligation; circumcision; vasectomy; breast reduction; sexual reassignment surgery; any services or supplies rendered for the purpose or with the intent of inducing conception; temporomandibular joint dysfunction (TMJ); cosmetic procedures; and submucous resection and/or other surgical correction for deviated nasal septum, other than for treatment of covered acute purulent sinusitis. Elective Treatment includes but is not limited to: allergy testing; treatment for acne; biofeedback-type services; infertility; hypnotherapy; learning disabilities, and weight reduction.

Injury means accidental bodily injury or injuries directly caused by specific accidental contact with another body or object while Your coverage is in force. It is unrelated to any pathological, functional, or structural disorder or Injury resulting directly and independently of all other causes, in Loss covered by the Policy. All related injuries and recurrent symptoms of the same or similar condition will be considered one Injury.

Pre-Existing Condition means any condition which originates, is diagnosed, treated or recommended for treatment within the 12 months immediately prior to Your Effective Date of coverage.

Prior Creditable Coverage means coverage provided in the United States under any individual or group: health benefits plan; insurance policy or certificate; service contract or HMO contract; or any government health benefit plan.

Sickness means Your bodily sickness, mental sickness, or Maternity which is not a Pre-existing Condition and which causes Loss while Your coverage is in force. Sickness includes pregnancy, Complications of Pregnancy and trauma related disorders due to injuries which otherwise do not meet the definition of an Injury. All related sicknesses and recurrent symptoms of the same or similar condition will be considered one Sickness.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which You are legally liable and which do not exceed the average rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Ingenix for such services or supplies.

STUDENT HEALTH CENTER – REFERRAL REQUIRED

Students must use the resources of the Student Health Center (SHC) prior to seeking medical care outside. SHC can administer treatment or issue a referral to a PPO provider. A referral issued by SHC must accompany the claim when submitted. SHC personnel must initial the claim form to verify referral. **Covered services received for medical treatment rendered outside of SHC for which no prior approval or referral has been obtained are excluded from coverage.**

A SHC referral for outside care is not necessary for the following conditions:

1. Medical emergency;
2. When the SHC is closed;
3. When the service is rendered at another facility during break or vacation period;
4. Medical care is received when the Student is more than 50 miles from campus;
5. Medical care obtained when a student is no longer able to use SHC due to change in student status;
6. Maternity; or
7. Mental & Nervous.

The SHC treats students only. Dependents of students are not eligible to use SHC.

Note: Description of SHC is provided for information purposes only. SHC is not affiliated with Columbian Life Insurance Company

PREFERRED PROVIDER ORGANIZATION

SAS, Inc. has contracted with First Health Network, a Preferred Provider Organization, to provide all insured by this plan with quality care at significantly reduced fees. You can choose to use a PPO physician or hospital or a provider of your own choice. Expenses incurred for medical treatment received by a PPO provider will be paid at the highest level of scheduled benefits. If you choose to receive medical treatment from a non-PPO pro-

vider, expenses incurred will be paid at the reduced benefit level. Refer to the Medical Benefits Schedule. PPO allowable only applies to services covered under the Policy. Benefits will be paid at the higher PPO scheduled benefit level for emergency treatment. Please confirm your provider is a member of the First Health Network prior to receiving services. A listing of participating providers is available by contacting First Health Network at 888-685-7774 or visiting the website at www.firsthealth.com.

CLAIM PROCEDURE

Secure a claim form from the Student Assurance Services, Inc. website or from the Servicing Agent, fill in the necessary information, attach all itemized doctor, prescription drug labels, and hospital bills and send to:

STUDENT ASSURANCE SERVICES, INC.
P.O. Box 196 • Stillwater, MN 55082

Proof of loss must be submitted to the address above within 90 days from the date of Injury or Sickness.

To check the status of your filed claim, please call the Claims Office from 8:00 a.m. to 4:30 p.m. (Central Time), Monday through Friday. The telephone number is: (800) 328-2739. The Student Assurance Services, Inc. website is: **www.sas-mn.com**

TO ENROLL FOR COVERAGE

Students have two options to enroll for coverage:

OPTION 1 - Enroll Online – Credit Card payment only

Students can complete an online Enrollment Form on the website **www.MyISUinsurance.com**.

OPTION 2 – Mail Enrollment Form and Payment

1. Students can download and print an Enrollment Form on the website **www.MyISUinsurance.com**,
2. Print all information legibly and indicate the coverage and options you desire.
3. Enclose your check payable to Student Health Insurance, or complete all credit card information.
4. Send the form and payment to Student Insurance Plan, Associated Insurance Plans International, Inc. P.O. Box 189, Libertyville, IL 60048.

Call (800) 452-5772 or email **office@aipinternational.com** for payment terms and information.

AUTOMATIC DEBIT FOR MONTHLY PREMIUMS

The monthly premium payment option is available if you purchase Spring/Summer coverage with an automatic debit from your banking or credit card account. Students must complete the Automatic Debit Authorization Form and return it with an Enrollment Form by the enrollment deadline date of February 10, 2010. Students who elect the monthly premium payment option whose coverage lapses (because of insufficient funds),will not be permitted to continue the monthly premium payment option and will be required to wait until the next enrollment period to reapply for benefits. For monthly premiums, your account will be debited on the 22nd of each month through July 22, 2010. **Important:** Please note there is no provision for cancellation of the automatic monthly debit payment option prior to the policy expiration date, other than upon a student's entry into the military service. Students interested in coverage for a term other than the Spring/Summer coverage should elect an option for payment other than monthly automatic debit.

> Keep this brochure as your summary of coverage — no individual policy will be issued — a master policy #13-64-0071-016-609-9 is issued to the University. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy. PRIVACY POLICY: You may obtain a detailed copy of Columbian Life's privacy policy from www.MyISUinsurance.com or by visiting the SAS, Inc. website at www.sas-mn.com.

If your coverage ends under this insurance plan and you obtain other coverage, student insurance qualifies as prior creditable coverage. A certification of coverage will be furnished upon written request to the Company.

Policy Form 9F138-CL

Accident & Sickness Plan

A Non-Renewable Term Policy

Designed for

Indiana State University
More. From day one.

2009 • 2010

Underwritten by

COLUMBIAN LIFE
INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: VESTAL PARKWAY EAST
P.O. BOX 1381 • BINGHAMTON, NY 13902-1381

SERVICING AGENT:

ASSOCIATED INSURANCE PLANS INTERNATIONAL, INC.

AIP International, Inc.
28085 Ashley Circle, Suite 201
Libertyville, IL 60048-9658
Phone: (800) 452-5772
Fax: (847) 281-8813

Email: **office@aipinternational.com**
Website: **www.MyISUInsurance.com**

Form No. 3740-CL-09-IN (Rev.10-09) U-71IN

Dear Student:
The Administration is making available to the students and their dependents a plan of Blanket Accident and Sickness Insurance (hereinafter called "plan" or "Plan") underwritten by Columbian Life Insurance Company. The coverage is designed to provide benefits for medical expenses arising from an accident or sickness including those which occur off campus and during interim vacations.
Participating in this plan is voluntary; however, we encourage you to review your personal situation to determine if you need coverage.

For assistance and questions about Insurance Benefits, ID cards, or problems, contact:
Associated Insurance Plans International, Inc.
Post Office Box 189 • Libertyville, Illinois 60048
Phone: (800) 452-5772
Email: **office@aipinternational.com**
website: **www.MyISUinsurance.com**

ELIGIBILITY

Undergraduate students taking 6 or more credit hours (3 credits in the summer), graduate students taking 6 or more credit hours, international students, students on internship, graduate assistants, fellows and students working on completing their thesis or dissertation are eligible to enroll in the plan. Coverage will become invalid for students who leave school within 31 days of their Effective Date of coverage. The Servicing Agent should be notified at that time by the student. Students who enroll in the plan may secure family coverage. Dependents must enroll in the plan when the student first enrolls in the plan, and must enroll for the same coverage as the student. Eligible dependents means the insured student's legal spouse and unmarried children (as defined in the Master Policy) under 23 years old who are residing with the student and not self-supporting.
The Plan Administrator reserves the right to determine if the student has met the Eligibility requirements. If the Plan Administrator later determines the Eligibility requirements have not been met, its only obligation is to refund premium.

EFFECTIVE AND EXPIRATION DATES

Your coverage becomes effective on the later of: the Policy Effective Date (08-22-2009); 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 08-21-2010, or when payment is due and unpaid.

ENROLLMENT PERIOD

Eligible students and dependents may enroll in the plan prior to the enrollment period deadline date for each term of coverage listed below:
Annual or Fall deadline date 09-23-2009; Spring/Summer Term deadline date 02-10-2010; Summer Term deadline date 06-17-2010.
If premium payment is received after the Effective Date of coverage for the term for which you are enrolling, your coverage becomes effective 12:01 a.m. following the date the proper premium is received by the Servicing Agent. Enrollment forms and premium payments postmarked by the US Postal Service after the enrollment period deadline date will not be accepted, unless you qualify for late enrollment. To qualify for late enrollment, you must submit an enrollment form and premium payment no later than 30 days after the qualifying event of involuntary loss of coverage under another health plan, marriage or birth/adoption of child. Call **(800)452-5772 or email office@aipinternational.com for enrollment information and partial year rates.**

CONTINUOUS COVERAGE

If an insured person was covered to the Expiration Date of the prior student health insurance policy of the Policyholder, he or she will not be denied benefits under this Policy for an Injury or Sickness which was the basis of a covered claim under the prior policy. The student must be enrolled in this Policy and pay the Premium within 31 days of the expiration date of the prior student health insurance policy. For purposes of this provision, benefits for the aggravation of an old Injury will be paid on the same basis as a Sickness.

MEDICAL BENEFITS SCHEDULE

BASIC INJURY OR SICKNESS BENEFITS
When your covered Injury or Sickness requires treatment by a Physician, the policy will provide benefits while your coverage is in force for the percentage shown of the PPO Allowable for charges incurred for covered services received from a PPO Provider, or the percentage shown of the Usual and Customary Charges (U&C) incurred for covered services received from a non-PPO Provider as scheduled below, **up to a Lifetime Maximum Benefit of $100,000 for Each Injury or Sickness**. Eligible expenses are subject to **$100 Deductible per person, per Policy year**. Covered services (as listed in the schedule of benefits and not excluded by the policy) received at the Student Health Center (SHC) are paid at 100% and the deductible is waived. Refer to SHC provision below in the Schedule of Benefits. Benefits will not be provided for services which are not listed in the Medical Benefits Schedule.

COVERED SERVICES	PPO Provider	Non-PPO Provider
I. INPATIENT		
a. HOSPITAL ROOM AND BOARD (semi-private room rate including general nursing care)	100% of PPO Allowable, up to $1,100/day	60% of U&C, up to $800/day
b. HOSPITAL INTENSIVE CARE (including 24 hour nursing care)	Paid under I. a.	Paid under I. a.
c. HOSPITAL MISCELLANEOUS INPATIENT (services and supplies including but not limited to: the cost of the operating room; laboratory tests; x-ray examinations; anesthesia; drugs - excluding take home drugs or medications; supplies; physiotherapy; preadmission tests)	Paid under I. a.	Paid under I. a.
d. SURGICAL TREATMENT (does not include assistant surgeon)	80% of PPO Allowable, up to $1,500	60% of U&C, up to $1,500
e. ANESTHETIST	20% of Surgical Treatment	20% of Surgical Treatment
f. PRIVATE DUTY NURSE (when medically necessary)	80% of PPO Allowable, up to $5,000	60% of U&C, up to $5,000
g. PHYSICIAN'S NON-SURGICAL VISITS (1 visit/day, not paid day of surgery)	80% of PPO Allowable, $50/visit, up to 3 visits	60% of U&C, $50/visit, up to 3 visits
h. MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE	Same as any Sickness, up to $10,000/Policy Year	Same as any Sickness, up to $10,000/Policy Year
II. OUTPATIENT		
a. HOSPITAL OUTPATIENT SURGICAL MISCELLANEOUS	100% of PPO Allowable, up to $1,100	60% of U&C, up to $800
b. SURGICAL TREATMENT (does not include assistant surgeon)	80% of PPO Allowable, up to $1,500	60% of U&C, up to $1,500
c. ANESTHETIST	20% of Surgical Treatment	20% of Surgical Treatment
d. PHYSICIAN'S NON-SURGICAL VISITS (1 visit/day, not paid day of surgery, includes injections)	80% of PPO Allowable	60% of U&C
e. PHYSIOTHERAPY: (1 visit per day; Benefit payable only for conditions that require Surgery or Hospital confinement; treatment must begin within 30 days following Surgery; or Hospital confinement; or Physician's release for rehabilitation)	80% PPO Allowable	60% of U&C
f. HOSPITAL EMERGENCY ROOM ($100 copay per visit, waived if admitted)	80% of PPO Allowable, up to $1,000	80% of U&C, up to $1,000
g. DIAGNOSTIC X-RAY AND LAB SERVICES	80% PPO Allowable, up to $400	60% of U&C, up to $400
h. CHEMOTHERAPY AND/OR RADIATION THERAPY (when prescribed by attending physician)	80% of PPO Allowable, up to $1,000	60% of U&C, up to $1,000
i. MISCELLANEOUS TESTS AND PROCEDURES (when no other Policy Benefit is provided)	Paid under II.g.	Paid under II.g.
j. MENTAL AND NERVOUS DISORDERS AND SUBSTANCE ABUSE	80% of PPO Allowable; up to $2,500/Policy Year	60% of U&C, up to $2,500/Policy Year
k. PRESCRIPTION DRUGS: (30 day supply per prescription; patient must pay and then submit a claim for reimbursement; refer to the Oupatient Prescription Drug Program below)	80% of U&C, up to $1,500/Policy Year	80% of U&C, up to $1,500/Policy Year
III. OTHER		
a. AMBULANCE SERVICES (professional ground service)	80% of U&C	80% of U&C
b. ORTHOPEDIC BRACES AND APPLIANCES	80% of U&C	60% of U&C
c. CAT SCANS AND MRI	80% of PPO Allowable, up to $1,000	60% of U&C, up to $1,000
d. CONSULTANT PHYSICIAN (when requested by the attending physician)	100% of PPO Allowable, up to $20	100% of U&C, up to $20
e. DENTAL TREATMENT (Injury to sound, natural teeth, includes X-rays, does not include biting or chewing injuries)	80% of U&C up to $250	80% of U&C, up to $250
f. WELL BABY CARE (inpatient confinement)	Same as any Sickness, up to 4 days	Same as any Sickness, up to 4 days
g. MATERNITY BENEFITS	Same as any Sickness	Same as any Sickness
h. MOTOR VEHICLE INJURY	Same as any Injury	Same as any Injury
i. SUPPLEMENTAL INJURY BENEFIT (outpatient treatment incurred in Physician office)	100% of PPO Allowable, up to $150	100% of U&C, up to $150
j. STUDENT HEALTH CARE SERVICE ONLY (Pregnancy test; annual pap smear provided up to $28 maximum; birth control $10 copay for a 30 day supply and $25 copay for 90 day supply; immunizations for Hepatitis, Meningitis, MMR, Diphtheria, Tetanus; and Quantiferon TB test)	100% of U&C	100% of U&C

For specific costs and further details of the coverage, including exclusions, reductions or limitations, contact the Servicing Agent or write the Plan Administrator.

PREMIUMS
For premium rates and coverage periods, refer to the Enrollment Form or visit the website at www.MyISUinsurance.com to view or print an Enrollment Form.

REFUND: A prorated premium refund will be made for the following situations only, if the Plan Administrator receives written notice, including the date of occurrence that: You have entered into full-time active-duty military service of any country; or you are a non-immigrant Foreign National and have permanently left the North American continent. Refunds may be subject to an administrative fee.

ADDITIONAL PROGRAMS : If you participate in the student insurance plan, the following programs are available to you. More detailed program information will be sent to you with your ID card. **These programs are not underwritten by Columbian Life Insurance Company.**

Scholastic Emergency Services, Inc. – This program provides protection while you travel. The program is administered by Assist America. It provides 24 hour assistance whenever you are traveling more than 100 miles away from home or school. Services include Emergency Evacuation, Supervised Repatriation and Return of Mortal Remains.

Ask Mayo Clinic – This program provides you telephone access to registered nurses. The program is administered through Mayo Foundation. You can call with questions about an illness, injury, or medical concern, 24 hours a day, 7 days a week.

Outpatient Prescription Drug Discount Program
Outpatient prescription drugs are provided through a prescription drug program managed by Co-Health Pharmacy Plan. Covered expenses are payable as indicated in the Medical Benefits Schedule. In order to access this program and receive the discounted prices for prescription drugs, you must present your ID Card to the pharmacy to identify yourself as a participant in the Plan. Once your prescription is filled, you will be required to pay for your prescripton and then file your claim for reimbursement. After you have reached the benefit maximum, you can continue to use your ID Card at a Co-Health pharmacy to receive discounted prices on your prescriptions. Medication not covered includes, but is not limited to: contraceptives, Accutane, Retin-A, Rogaine, Renova, Growth Hormones, and Viagra. You can locate a participating pharmacy by calling (888) 373-0881 or visit the website at www.cohealthusa.com.

INDIANA STATE UNIVERSITY
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, either complete this enrollment form or enroll on-line at: www.MyISUInsurance.com. Indicate premium selected below. If purchasing dependent coverage, complete dependent information below.

☐ Undergraduate ☐ Graduate ☐ International Student ID: ____________________

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** 08-22-2009 to 08-21-2010	**Fall** 08-22-2009 to 01-08-2010	**Spring/Summer** 01-09-2010 to 08-21-2010	**Summer** 05-16-2010 to 08-21-2010	***Monthly**
Student Only	❐ $ 820.00	❐ $ 322.00	❐ $ 518.00	❐ $ 232.00	❐ $ 75.00
Student and Spouse	❐ $ 3,280.00	❐ $ 1,256.00	❐ $ 2,044.00	❐ $ 896.00	❐ $ 280.00
Student, Spouse and Child	❐ $ 4,510.00	❐ $ 1,724.00	❐ $ 2,806.00	❐ $ 1,228.00	❐ $ 382.00
Student and Child	❐ $ 2,050.00	❐ $ 789.00	❐ $ 1,281.00	❐ $ 564.00	❐ $ 178.00
Each Additional Child	❐ $ 1,230.00	❐ $ 477.00	❐ $ 773.00	❐ $ 342.00	❐ $ 109.00

Coverage becomes effective on the later of the Policy Effective Date (08-22-2009); 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 08-21-2010, or when payment 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. Any refund will be subject to $25 administrative fee.
This plan has an Enrollment Period, refer to the brochure that accompanies this Enrollment Form.

* Monthly premium is available only if purchasing Spring/Summer 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.

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 **Spring/Summer**: $____________.
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 ___/___/___