

Rockhurst University
2009-2010 Injury and Sickness Plan
Dependent Enrollment Form

I am a full time student at Rockhurst University and have enrolled in the Injury and Sickness coverage under the University's student insurance plan. I also elect to enroll my dependent(s) as indicated below. Eligible dependents are spouse and children to age 19, (25 if full time student).

	Annual	Fall	Spring/Summer	Summer
Dependent Rates:	8/17/09-8/17/10	8/17/09-1/18/10	1/19/09-8/15/10	6/7/10-8/15/10
Spouse	<input type="checkbox"/> \$2,359	<input type="checkbox"/> \$900	<input type="checkbox"/> \$1,459	<input type="checkbox"/> \$487
Children	<input type="checkbox"/> \$2,319	<input type="checkbox"/> \$885	<input type="checkbox"/> \$1,434	<input type="checkbox"/> \$478
Spouse & Children	<input type="checkbox"/> \$4,678	<input type="checkbox"/> \$1785	<input type="checkbox"/> \$2,893	<input type="checkbox"/> \$965

STUDENT INFORMATION:

Primary Insured Student Name: _____
First Name
Middle Initial
Last Name

Student Social Security Number _____ Student School ID Number: _____

Student Gender: Male Female (circle one) Student Date of Birth: _____ - _____ - _____
Month
Day
Year

Mailing Address: _____
Number and Street

_____ City State Zip Code

Telephone Number: (____) _____ E-mail address: _____

To enroll dependents, list dependents to be insured below. Dependent coverage is available only if the student is also enrolled in this plan.

Last Name First Name MI Date of Birth Social Security Number

Spouse: _____

Child: _____

Child: _____

Notice to Student: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) he/she has carefully read the brochure and elects to enroll dependents as indicated on this enrollment form; 2) rates are not pro-rated other than as listed on this enrollment card; 3) dependents meet the eligibility requirements of this coverage as described in the brochure; and 4) if it is later determined that the dependents are not eligible, the premium will be refunded. Premium will not be refunded except for ineligibility or entrance into the armed forces.

Student Signature: _____ Date: _____

Enrollment & Payment Procedure:

Mail this enrollment form with payment in US dollars to Summit America Insurance Services, 7400 College Boulevard, Suite 100, Overland Park, KS. 66210. Make check or money order payable to Summit America Insurance Services, LC. To charge your premium to American Express, Visa or Master Card, complete the charge card authorization below and fax to Summit America at 913-327-0201. Note: We cannot accept payment by phone.

Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payment. Renewal notices will not be sent for re-enrollment.

Credit Card Authorization

American Express/Visa/MasterCard # _____

Exp Date: ____/____ Charge Amount \$ _____

Print Name of Cardholder: _____

Signature: _____