

**Rockhurst University  
2009-2010 Injury and Sickness Plan  
Voluntary Enrollment Form**

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

<b>Rates:</b>	Annual 8/17/09-8/15/10	Fall 8/17/09-1/18/10	Spring/Summer 1/19/09-8/15/10	Summer 6/7/10-8/15/10
Student Only	<input type="checkbox"/> \$1,896.00	<input type="checkbox"/> \$727.00	<input type="checkbox"/> \$1,169.00	<input type="checkbox"/> \$389.00
Student & Spouse	<input type="checkbox"/> \$7,655.00	<input type="checkbox"/> \$2,902.00	<input type="checkbox"/> \$4,753.00	<input type="checkbox"/> \$1,582.00
Student & Children	<input type="checkbox"/> \$7,556.00	<input type="checkbox"/> \$2,863.00	<input type="checkbox"/> \$7,693.00	<input type="checkbox"/> \$1,560.00
Spouse, Spouse & Children	<input type="checkbox"/> \$13,315.00	<input type="checkbox"/> \$5,038.00	<input type="checkbox"/> \$8,277.00	<input type="checkbox"/> \$2,753.00

**STUDENT INFORMATION:**

Primary Insured Student Name: \_\_\_\_\_  
First Name Middle Initial Last Name

Student Social Security Number \_\_\_\_\_ Student School ID Number: \_\_\_\_\_

Student Gender: Male Female 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.**

<u>Last Name</u>	<u>First Name</u>	<u>MI</u>	<u>Date of Birth</u>	<u>Social Security Number</u>
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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 or fax 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 Credit Card Authorization section and fax or mail to Summit America. Fax number: 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**

AmEx/Visa/MasterCard # \_\_\_\_\_

Exp Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Charge Amount \$ \_\_\_\_\_

Print Name of Cardholder: \_\_\_\_\_

Signature: \_\_\_\_\_