DEPENDENT MEDICAL INSURANCE ENROLLMENT FORM 2010-2011

*This enrollment form is ONLY FOR DEPENDENTS of students/scholars currently insured in the health insurance plan for the **State University of New York***

Dependent coverage is available at the time the student is enrolled or within 31 days of marriage, birth, or arrival in the US.

Student Information: **Please circle one:** **Mr. Mrs. Ms. Dr.** **Please circle one:** **Student Scholar**

Last Name _____ First Name _____

SUNY Campus_____ Student ID/Social Security #_____

Home Country_____ Date of Birth (mm/dd/yyyy)_____

US Mailing Address _____

City, State, Zip _____

Telephone _____ Email _____

Dependent Information

Name of Dependents:	Date of Birth (mm/dd/yyyy)	**Circle One**
Spouse _____	_____	**Female Male**
Child _____	_____	**Female Male**
Child _____	_____	**Female Male**
Child _____	_____	**Female Male**
Child _____	_____	**Female Male**

	Dates	**Spouse**	**Children**	**Total**
Annual	8/15/10-8/14/11	☐ $2,340.00	☐ $1,260.00	
Quarterly	8/15/10-11/14/10	☐ $585.00	☐ $315.00	
	11/15/10-02/14/11	☐ $585.00	☐ $315.00	
	2/15/11-5/14/11	☐ $585.00	☐ $315.00	
	5/15/11-8/14/11	☐ $585.00	☐ $315.00	
Monthly* (or fraction of)		☐ $195.00	☐ $105.00	
Start Date ____/___/_____ Number of Months _____		Monthly premium $_____ x # of Months _____ =		_____

* Available only when a term of less than three months is required, or in order to provide coverage for dependents arriving prior to the beginning of a term. **Coverage cannot extend past 08/14/11.**

Make checks payable to ***HTH Worldwide Insurance Services*** and mail with enrollment form to HTH Worldwide Insurance Services, One Radnor Corporate Center, Suite 100, Radnor PA 19087. REMITTANCE IN U.S. FUNDS ONLY

I understand that expenses incurred by my dependents for conditions for which they receive treatment, medical advice, or had symptoms prior to effective date of coverage may not be covered until they have been enrolled in the plan for six continuous months.

Signature of Student/Scholar_____Date_____

Reminder for Dependents: Please enclose a photocopy of your 1-94. This is required by the Insurance Company Verification.

Verification: I verify that the above applicant(s) is/are dependents of _____ an international student duly enrolled in the SUNY International Student & Scholar Insurance Program.

Verified by: (name &title, i.e. FSA)_____ Date_____