

DEPENDENT MEDICAL INSURANCE ENROLLMENT FORM 2009 – 2010

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 U.S.

Student Information

Last Name _____ First Name _____
 SUNY Campus _____ Student ID or Social Security # _____
 Home Country _____
 U.S. Mailing Address _____
 City, State, Zip _____
 Telephone _____ Email _____
 Birth Date: (mm/dd/yyyy) _____ Female Male Student Scholar

Dependent Information

Name of Dependents:	Date of Birth (mm/dd/yyyy)	
Spouse _____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child _____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child _____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male
Child _____	_____	<input type="checkbox"/> Female <input type="checkbox"/> Male

Annual	Period of Coverage	Spouse	Children	Total
	8/15/09 to 8/14/10	<input type="checkbox"/> \$2,136.00	<input type="checkbox"/> \$1,152.00	
Quarterly	8/15/09 to 11/14/09	<input type="checkbox"/> \$534.00	<input type="checkbox"/> \$288.00	
	11/15/09 to 2/14/10	<input type="checkbox"/> \$534.00	<input type="checkbox"/> \$288.00	
	2/15/10 to 5/14/10	<input type="checkbox"/> \$534.00	<input type="checkbox"/> \$288.00	
	5/15/10 to 8/14/10	<input type="checkbox"/> \$534.00	<input type="checkbox"/> \$288.00	
Monthly* (or fraction of)		<input type="checkbox"/> \$178.00	<input type="checkbox"/> \$96.00	
Begin Coverage on ___/___/___ and continue for ___ 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 8/14/10.

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 for, medical advice, or had symptoms, prior to effective date of coverage, may not be covered until they have been enrolled in the plan for 6 continuous months.

Signature of Student _____ Date _____

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

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

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