THE COLLEGE OF NEW JERSEY
DEPENDENT INSURANCE ENROLLMENT CARD
COMPLETE THIS FORM IF YOU ARE A PART-TIME STUDENT OR A FULL-TIME STUDENT ADDING DEPENDENT COVERAGE ONLY

(PLEASE PRINT)
Student's Name________________________ /_____________________________________/_________________________
Last First MI

Permanent US Address____
Street or PO Box City State Zip

School ID #_________________________ Date of Birth______________ Phone # (___)__________________

Expected Graduation Date: _________/___________
Month Year

List Dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan.

	Last Name	First Name	MI	Date of Birth
Spouse:	__________________	__________________	________	____________
Child:	__________________	__________________	________	____________
Child:	__________________	__________________	________	____________

Student Signature: ____

NOTE: Please remit payment directly to Bollinger Inc. 101 JFK Parkway, Short Hills, New Jersey 07078

Detach and Retain for your records

Monumental Life Insurance Company
Cedar Rapids, Iowa
Hospitalization I.D. Card

NAME___________________________________
Last First MI
SCHOOL THE COLLEGE OF NEW JERSEY
POLICY NO. C-528E
TYPE OF COVERAGE Basic and Major Medical Coverage
EFFECTIVE DATES 8/15/08 to 8/15/09

CLAIM PROCEDURES

In the event of injury or illness students should contact TCNJ Student Health Services at once to obtain a claim form or you may obtain on line at www.BollingerColleges.com/TCNJ. All claim payments are made from the Short Hills office of Bollinger Inc. Proofs of loss must be submitted within 90 days following the date of accident or start of sickness.

PREFFERED PROVIDER NETWORK:

CHN SOLUTIONS
www.chn.com

PLAN ADMINISTRATOR:

Bollinger Insurance Solutions
101 JFK Parkway
Short Hills, NJ 07078
866-267-0092

PLEASE CHECK ALL APPROPRIATE BOXES:

A ☐ Full-Time (Dependents)   B ☐ Part-Time

Full-time students may purchase optional coverage for themselves or for themselves and all family members.

		Annual (A-)	Spring/Summer (J-)	Summer (S-)
A	Self	☐ $120.00	☐ $ 120.00	☐ N/A
B	Spouse	☐ $1,091.00	☐ $ 656.00	☐ $306.00
C	Each Child	☐ $644.00	☐ $ 387.00	☐ $181.00

D Optional Repat/Med Evac (Per Insured) ☐ $ 26.00

Effective/Expiration Dates: Annual ☐ 8/15/08 - 8/15/09   Spring/Summer ☐ 1/15/09- 8/15/09
Summer ☐ 5/15/09 - 8/15/09

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. It is the student's responsibility for timely renewal payments. By signing below, the student acknowledges the following: 1) He/She has carefully read the coverage description and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; 4) If it is later determined that the student is not eligible, the premium will be refunded; and 5) Other than for ineligibility, the premium is not refundable.

METHOD OF PAYMENT

☐ Enclosed is my check (Make check payable to BOLLINGER)
☐ I hereby authorize that you charge my credit card ☐ VISA ☐ MASTERCARD

Credit Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Expiration Date Month ☐☐ Year ☐☐

Cardholder Name (Printed)______________________________

Cardholder's Signature______________________________ **Date:**______________