

LAST NAME															FIRST NAME														
Mo.			Day			Year			STUDENT ID NUMBER					M	F	TELEPHONE NUMBER													
MAILING ADDRESS																									APARTMENT NUMBER				
CITY															STATE		ZIP CODE					E-MAIL							

PREMIUM RATES

	Annual 8/28/11 to 8/28/12	Fall-Quarter 8/28/11 to 11/30/11	Winter-Quarter 11/30/11 to 3/08/12	Spring-Quarter 3/08/12 to 6/01/12	Summer-Quarter 6/01/12 to 8/28/12
Student Only	<input type="checkbox"/> \$ 330.00	<input type="checkbox"/> \$ 85.00	<input type="checkbox"/> \$ 85.00	<input type="checkbox"/> \$ 85.00	<input type="checkbox"/> \$ 85.00
Spouse Only*	<input type="checkbox"/> \$ 847.00	<input type="checkbox"/> \$ 212.00	<input type="checkbox"/> \$ 212.00	<input type="checkbox"/> \$ 212.00	<input type="checkbox"/> \$ 212.00
Each Child*	<input type="checkbox"/> \$ 424.00	<input type="checkbox"/> \$ 106.00	<input type="checkbox"/> \$ 106.00	<input type="checkbox"/> \$ 106.00	<input type="checkbox"/> \$ 106.00

* Dependent coverage is only available if the Student enrolls in this student insurance program.
Premium rates are not pro-rated other than as listed above.

Indicate Total Premium Submitted _____

Signature - Student - Parent - Guardian

Date

STUDENT NOTICE - By placement of your signature above, acknowledgement is made that: 1) you have carefully read the insurance coverage brochure; 2) you and any insured family member meet the eligibility requirements as described within the insurance brochure; 3) if at any time it is determined you, or any insured family member, did not meet the eligibility requirements for this coverage, the only liability the Company has is the refund of premium, subject to any claims for which benefits had been paid prior to discovery of the ineligibility; 4) the Company assumes no responsibility for notification to the insured prior to or at the termination of coverage for any insured period.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a crime and may be subject to fines or confinement in prison.

METHOD OF PAYMENT

CHECK/MONEY ORDER

PAYABLE TO: BOLLINGER, INC.

(PLEASE USE THE RETURN ENVELOPE ENCLOSED FOR YOUR CONVENIENCE OR MAIL TO BOLLINGER INC., P.O. BOX 398, SHORT HILLS, NJ 07078-0398)

* TO EXPEDITE YOUR ENROLLMENT IN THIS INSURANCE PROGRAM, PLEASE WRITE LOUISIANA TECH UNIVERSITY ON YOUR CHECK OR MONEY ORDER.

CREDIT CARD

(COMPLETE CREDIT CARD INFORMATION ON REVERSE SIDE)

LOUISIANA TECH UNIVERSITY
Student Medical Benefit Plan - I.D. Card

This is to certify that as of August 28, 2011, insurance coverage is provided in accordance with the terms and provisions of Policy No. CLA503H issued to the above named college for the student named below.

Name _____ Student I.D. _____

Street Address _____

Town _____ State _____ Zip Code _____

This coverage expires August 28, 2012.

UNDERWRITTEN BY:
Monumental Life Insurance Company
Cedar Rapids, Iowa

ADMINISTERED BY:

Bollinger
Insurance Services
P.O. Box 727
Short Hills, NJ 07078
1-866-267-0092

PREFERRED PROVIDER NETWORK:



Preferred Provider Network, claim forms and plan benefits available on website: www.BollingerColleges.com/LTU

