

FELICIAN COLLEGE: Dependent Enrollment Card

(PLEASE PRINT)

Student's Name _____ / _____ / _____
Last First MI

Permanent US Address _____
Street or PO Box City State Zip

Student 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 Hospitalization I.D. Card

NAME _____ Last First MI

Student ID# _____

SCHOOL: FELICIAN COLLEGE

POLICY NO.: C-507F

TYPE OF

COVERAGE: Basic and Major Medical Coverage

EFFECTIVE DATES: 8/15/09 to 8/15/10

