

**Complete this form only if you wish to purchase Dependent Coverage or Optional Major Medical Coverage.**

**PLEASE PRINT**

Student Name: \_\_\_\_\_  
 Last (Family) name First (Given) name Middle Initial

Permanent Address: \_\_\_\_\_  
 Street or PO Box City State Zip

Mailing Address: \_\_\_\_\_  
 Street or PO Box City State Zip

Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School Phone: \_\_\_\_\_

**Complete information below for Dependents to be insured.**

SPOUSE: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  Male  Female  
 Last (Family) name First (Given) name

CHILD: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  Male  Female  
 Last (Family) name First (Given) name

CHILD: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  Male  Female  
 Last (Family) name First (Given) name

CHILD: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  Male  Female  
 Last (Family) name First (Given) name

CHILD: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  Male  Female  
 Last (Family) name First (Given) name

**IMPORTANT:** 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. By signing below, the student acknowledges the following: (1) He/she has carefully read the plan 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 plan description; (4) If it is later determined that the student is not eligible, the premium will be refunded; and (5) Other than eligibility, the premium is not refundable.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

	ANNUAL 06/30/2012-08/01/2013	SPRING/SUMMER 01/01/2013-08/01/2013
<b>Basic coverage</b>		
Student	<i>This Basic plan is included in your Student fees.</i>	
Spouse - Under age 30	<input type="checkbox"/> \$1022.00	<input type="checkbox"/> \$610.00
Spouse - Age 30 & over	<input type="checkbox"/> \$1534.00	<input type="checkbox"/> \$915.00
Each Child	<input type="checkbox"/> \$ 525.00	<input type="checkbox"/> \$314.00
<b>Optional Major Medical</b>		
<i>This premium is in addition to the Basic Coverage premium.</i>		
Student - Under age 30	<input type="checkbox"/> \$ 199.00	<input type="checkbox"/> \$115.00
Student - Age 30 & over	<input type="checkbox"/> \$ 239.00	<input type="checkbox"/> \$138.00
Spouse - Under age 30	<input type="checkbox"/> \$ 240.00	<input type="checkbox"/> \$144.00
Spouse - Age 30 & over	<input type="checkbox"/> \$ 360.00	<input type="checkbox"/> \$215.00
Each Child	<input type="checkbox"/> \$ 240.00	<input type="checkbox"/> \$144.00

**Payment Instructions:** Make check or money order payable to Bollinger, Inc. in U.S. dollars drawn on a U.S. bank. Mail this enrollment card with premium payment to Bollinger, Inc., P.O. Box 398, Short Hills, NJ 07078. Your cancelled check is your only receipt of coverage. **Optional coverage(s) (including Dependent coverage - except for newborns) - must be purchased simultaneously and in conjunction with the Basic & Major Medical Coverage at the time of initial enrollment.**