

SAINT JOHN'S UNIVERSITY

2009-2010 Student Accident & Sickness Insurance Enrollment Form

COLUMBIAN LIFE INSURANCE COMPANY • Home Office: Chicago, IL • Administrative Service Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381
 COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • Home Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381

Please return this form no later than September 11, 2009. To enroll, complete the Enrollment Form and make your check payable to Saint John's University. Return it to Student Accounts, Saint John's University, P.O. Box 5000, Collegeville, MN 56321.

Student's Name _____ Soc. Sec. # _____
(Please Print) (Last) (First) (MI)

Birthdate _____ Phone # _____ email: _____
(MM/DD/YY)

Banner ID # _____ UnderGrad Grad International

Home Address _____
(Street) (City) (State) (Zip)

School Address _____
(Street) (City) (State) (Zip)

PREMIUM SCHEDULE (Indicate Premium Selected)

- Student Only \$ 880
- Student and Two or more Dependents \$5,150
- Student and One Dependent \$3,440
- Optional Sports Coverage \$ 990

Students must be enrolled in the Basic Injury and Sickness Benefits of this Insurance plan in order to purchase Optional Intercollegiate Sports Coverage. Sports Coverage will terminate when your Accident and Sickness Insurance plan terminates or when the premium is due and unpaid. List dependent information if purchasing dependent coverage.

Coverage becomes effective on the later of the Policy Effective Date (08-10-2009); the first day of the term for which the proper premium has been paid; or 12:01 a.m. following the date the proper premium is received by the School. All coverage expires on 08-09-2010, or when payment is due and unpaid. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. No refunds, except as provided in the Master Policy. Any refunds will be subject to a \$25 administrative fee. This plan has an Enrollment Period, refer to the Brochure that accompanies this Enrollment Form.

DEPENDENT INFORMATION (Complete if purchasing dependent coverage)

Spouse's Name _____ Birthdate _____
Soc. Sec. # _____ MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # _____ MM/DD/YY

Child's Name _____ Birthdate _____
Soc. Sec. # _____ MM/DD/YY

I have read the details concerning the Student Accident and Sickness Insurance Plan. I do not have comparable coverage and would like to purchase the insurance coverage. I understand the student only premium and the optional sports coverage (if selected) will be added to my tuition account.

I understand the policy excludes benefits for a Pre-Existing Condition, not subject to Credit for Prior Coverage, until I am continuously covered under the policy for 12 months.

Student Signature _____ Date ____/____/____