

COLLEGE OF SAINT BENEDICT

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 18, 2009. Make your check payable to College of Saint Benedict and return it to Student Accounts, College of Saint Benedict, 37 College Avenue South, St. Joseph MN 56374.

Student's Name (Please Print) (Last) (First) (MI) Birthdate: (MM/DD/YY)

Soc. Sec. # [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] [ ] Banner ID # UnderGrad Grad International

Phone #: email:

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

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

PREMIUM SCHEDULE (Indicate Premium Selected)

- Student Only \$ 780
Student and One Dependent \$3,253
Student and Two or more Dependents \$4,903
Optional Sports Coverage \$ 900

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 College. All coverage expires on the earlier of: 08-09-2010, or when payment for your Accident and Sickness coverage 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.

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 student only premium 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 / /