

PLEASE CHECK ONLY ONE BOX:

Basic Medical Coverage	Annual	Fall	Spring/Summer	Summer	13 Month	14 Month
A. Student	<input type="checkbox"/> \$ 984.00	<input type="checkbox"/> \$ 404.00	<input type="checkbox"/> \$ 633.00	<input type="checkbox"/> \$ 306.00	<input type="checkbox"/> \$ 1,088.00	<input type="checkbox"/> \$ 1,168.00
B. Student & Spouse	<input type="checkbox"/> \$ 3,249.00	<input type="checkbox"/> \$ 1,280.00	<input type="checkbox"/> \$ 2,015.00	<input type="checkbox"/> \$ 958.00	<input type="checkbox"/> \$ 3,559.00	<input type="checkbox"/> \$ 3,866.00
C. Student & Child(ren)	<input type="checkbox"/> \$ 3,249.00	<input type="checkbox"/> \$ 1,280.00	<input type="checkbox"/> \$ 2,015.00	<input type="checkbox"/> \$ 958.00	<input type="checkbox"/> \$ 3,559.00	<input type="checkbox"/> \$ 3,866.00
D. Student, Spouse & Child(ren)	<input type="checkbox"/> \$ 5,630.00	<input type="checkbox"/> \$ 2,219.00	<input type="checkbox"/> \$ 3,494.00	<input type="checkbox"/> \$1,663.00	<input type="checkbox"/> \$ 6,100.00	<input type="checkbox"/> \$ 6,568.00

Period:	Annual	08-24-09 to 08-23-10	Fall	08-24-09 to 01-11-10
	13 Month	07-24-09 to 08-23-10	Spring/Summer	01-11-10 to 08-23-10
	14 Month	06-24-09 to 08-23-10	Summer	05-17-10 to 08-23-10

NOTICE TO STUDENT: Coverage will be effective the date the correct payment is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. It is the student's responsibility for timely renewal payments. By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure 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 brochure; 4) If it is later determined that the student is not eligible, the payment will be refunded; and 5) Other than eligibility, the payment is not refundable.

Signature of Student _____ Date _____

CLAIMS INSTRUCTIONS

Claims must be submitted to Bollinger, Inc. within 90 days after date of treatment. Mail all medical and hospital bills along with patient's name and insured student's name, address, social security number and name of the university under which the student is insured to:

Bollinger, Inc.
P.O. Box 727
Short Hills, NJ 07078-0727
Telephone: 1-866-267-0092

BALL STATE UNIVERSITY
STUDENT INSURANCE ENROLLMENT CARD 2009-2010
(PLEASE PRINT)

Student's Name _____
Last First Middle

Male Female

Permanent US Address _____
Street or PO Box City State Zip Code

Student ID # _____ Date of Birth _____ Phone# _____ Expected Graduation Date _____

List dependents to be insured below. Dependent coverage is available only if the student is also insured under this plan.

	Last Name	First Name	M/F	Date of Birth
Spouse	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____
Child:	_____	_____	_____	_____

Payment Instructions: Make check or money order payable to Bollinger, Inc. in US dollars. Mail payment Collegiate Risk Management, Inc. P.O. Box 850001, Orlando, FL 32885-0164.

Your cancelled check is your only receipt and notification of coverage. An effort will be made to send payment renewal notices if paying by installments. It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.

**Detach and Retain for your records
2009-2010**

**Temporary Identification card
Monumental Life Insurance Company**

Insured (Name of Student)

If rate has been paid, the Student whose name appears above has been insured under policy number:

**Ball State University
Policy # CIN200F**