BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

For Exchange Students and their Dependents
Florida International University 2009 – 2010

Student Health and Accident Blanket Insurance Application (Please Print)

66960-0509R SU

Student's Name (Last, First, Middle)		Date of Birth (mmddyy)
Permanent U.S. Address (Street, Apt. #, City, State, Zip)		Country of Citizenship:
E-mail Address		FIU Panther #
Sex: ☐ Female ☐ Male	Phone #: ( )	Cell #: ( )
Immigration Status: ☐ J-1 ☐ F-1 ☐ Other	Other Immigration Status–Please Specify:	

Dependent coverage is available only if the student is also insured under this plan and will only be insured for the same dates of coverage. List below dependents to be insured.

	Last Name	First Name	Male/Female	Date of Birth (mmddyy)
Spouse				
Child				
Child				
Child				

Premium Rates *Please check all appropriate boxes.*

Note: Exchange Students must pay entire amount at time of enrollment

	Annual 08/20/09 – 5/19/10	**Fall 08/20/09 – 01/19/10**	**Spring 01/01/10 – 05/19/10**
Student (International)	☐ $1,374	☐ $687	☐ $687
Spouse Only	☐ $3,435	☐ $1,568	☐ $1,568
Child(ren)	☐ $1,787	☐ $894	☐ $894

Important Payment Instructions: At the time of enrollment, please submit a cashier's check or money order payable to Blue Cross and Blue Shield of Florida to the Office of Education Abroad, FIU, University Park, DM 441, 11200 SW 8th Street, Miami, FL 33199. If you have questions please contact Collegiate Risk Management at 1-800-922-3420 or the Office of Education Abroad at 305-348-1913.

Method of Payment

☐ Cashier's Check ☐ Money Order **Payment Date** _______ / _______ / ___________

Please bill my credit card for any insurance at FIU as follows:

☐ Master Card ☐ Visa Card Number ______________________ Cardholder's Name ____________________________

Expiration Date ______________ Amount Charged _____________ Authorization Signature_________________________

Notice to Students: By signing below, the student acknowledges the following: 1) I have carefully read the brochure and is enrolling as indicated on this application, 2) I understand that my Benefit Booklet will only be made available online at www.collegiaterisk.com. At any time, I may request paper copies of these materials be mailed to me by contacting BCBSF's Customer Service Department at 1-800-664-5295, 3) Rates are not pro-rated other than as listed in this application; 4) I meet the eligibility requirements for this coverage as described in the brochure; 5) If it is later determined that the student is not eligible, the payment will be refunded; and 6) Other than eligibility, the payment is not refundable. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files an application containing incomplete or misleading information is guilty of a felony of the third degree.

Signature of Student____ Date_________________