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

For Graduate Assistants (DEPENDENTS ONLY)
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)			
E-mail Address			FIU Panther #
Sex: ☐ Female ☐ Male	Phone #: ( ) Cell #: ( )	Expected Graduation Date:	FIU Dept:
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	Social Security #	Male/Female	Date of Birth (mmddyy)
Spouse					
Child					
Child					
Child					

Premium Rates *Please check all appropriate boxes.*

Dependents of The University Graduate School (UGS) students, either the Graduate Assistants or Fellowship recipients who are eligible for the insurance determined on a full semester appointment, are eligible for insurance for the same dates of coverage as the GA's participating in the program.

	Annual 08/20/09 – 8/19/10	**Fall 08/20/09 – 02/19/10**	**Spring / Summer 02/20/10 – 08/19/10**	**Summer 05/01/10 – 08/19/10**
Spouse Only	☐ $4,580.00	☐ $2,290.00	☐ $2,290.00	☐ $1,386.72
Child(ren)	☐ $2,382.00	☐ $1,191.00	☐ $1,191.00	☐ $721.22

Important Payment Instructions: At the time of enrollment, you may submit a check, cashier's check or money order, payable to Blue Cross and Blue Shield of Florida, and mail to Collegiate Risk Management, 110 Athens Street, Tarpon Springs, FL 34689 prior to the coverage start date for the period for which you are enrolling your dependents in the program (remember this must coincide with your term dates with the school) or pay via credit card, by filling in the information below:

Method of Payment

☐ Cashier's Check ☐ Money Order ☐ Check **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. I further understand that upon enrollment in this program, I may not be eligible for cancellation of the insurance coverage or a refund of any premium I have paid; request for cancellation must be made in writing to the Medical School. 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_____