



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

**For Medical Students and Dependents**  
**Florida International University –**  
**Herbert Wertheim College of Medicine 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)		Social Security #	
E-mail Address		FIU Panther #	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Phone #: (    ) Cell #: (    )	Expected Graduation Date:	FIU Dept:

**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.*

**Note: Payments for the Student Health Insurance may be made annually, or in two equal installments, by August 3, 2009 and January 3, 2010. Submit this application, along with your payment, made payable to Blue Cross and Blue Shield of Florida, to Collegiate Risk Management, 110 Athens Street, Tarpon Springs, Florida 34689. Disability Insurance is NOT part of this application. This application is intended for Health Insurance only. Premium for your Disability Insurance needs to be paid to the Office of Student Affairs at the College of Medicine. If questions call 1-800-922-3420 for information. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received. Applications may be obtained by going online at [www.collegiaterisk.com](http://www.collegiaterisk.com).**

	Annual (08/03/09 – 8/02/10)	1st Payment (08/03/09 – 01/02/10)	2nd Payment (01/03/10 – 8/02/10)
Student	<input type="checkbox"/> \$1,832	<input type="checkbox"/> \$916	<input type="checkbox"/> \$916
Spouse Only	<input type="checkbox"/> \$4,580	<input type="checkbox"/> \$2,290	<input type="checkbox"/> \$2,290
Child(ren)	<input type="checkbox"/> \$2,382	<input type="checkbox"/> \$1,191	<input type="checkbox"/> \$1,191

**Method of Payment**

Cashier's Check  Money Order      **Payment Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

**NOTE: You may enroll via credit card on-line by going to [www.collegiaterisk.com](http://www.collegiaterisk.com), put in FIU in upper right hand corner on the home page, when at the FIU home page, click on Medical Student Application and the on-line link to Credit Card Application.**

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](http://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 \_\_\_\_\_