

**Scholar Information**

Scholar's Name (Last, First, Middle)			Date of Birth (mmddyy)
Permanent U.S. Address (Street, Apt. #, City, State, Zip)			PO #
E-mail Address			FIU Panther #
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Phone #: (    )	Cell #: (    )	FIU Dept:
Immigration Status: <input type="checkbox"/> J-1 <input type="checkbox"/> H-1B <input type="checkbox"/> F-1 <input type="checkbox"/> Other	Other Immigration Status--Please Specify:		

**Covered Dependent Information**

Dependent Coverage is available only if the scholar 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				

**Rates**

*These rates below are valid until August 19, 2010. Total premiums must be paid at enrollment.*

**Note: Scholars must pay the full premium for the length of their authorized stay. Total premium must be paid at the time of enrollment. Any fraction of a month must be calculated as a whole month.**

I want my insurance to begin on \_\_\_/\_\_\_/\_\_\_ for a period of \_\_\_ (number of months)

Please indicate coverage selection by marking the appropriate box:

	Monthly Premium	x	Number of Months	=	Total Premium
<input type="checkbox"/> Scholar	\$153.00	x	_____	=	\$ _____
<input type="checkbox"/> Scholar + Spouse	\$535.00	x	_____	=	\$ _____
<input type="checkbox"/> Scholar + Child(ren)	\$352.00	x	_____	=	\$ _____
<input type="checkbox"/> Family	\$733.00	x	_____	=	\$ _____

**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 International Student and Scholar Services, GC 355 (University Park) or WUC 363 (Biscayne Bay Campus). If you have questions, please contact Collegiate Risk Management at 1-800-922-3420.**

**Method of Payment:**  Cashier's Check  Money Order

**Payment Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Master Card  Visa    Card Number \_\_\_\_\_    Cardholder's Name \_\_\_\_\_

Expiration Date \_\_\_\_\_    Amount Charged \_\_\_\_\_    Authorization Signature \_\_\_\_\_

**Coordination of Benefits Information**

Will you or any covered dependent have any other medical insurance while insured under this plan?

- No    If "No" is checked, then no other information needs to be provided.
- Yes    If "Yes" is checked, then you will be receiving a short questionnaire to complete.

**Scholar Authorization**

**Notice to Scholars:** By signing below, the scholar 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 scholar 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 Office of International Student & Scholar Services. 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 Scholar \_\_\_\_\_ Date \_\_\_\_\_