

**DEPENDENT MEDICAL INSURANCE ENROLLMENT FORM      2007 – 2008**

***This enrollment form is ONLY FOR DEPENDENTS of students/scholars currently insured in the health insurance plan for the State University of New York***

Dependent coverage is available at the time the student is enrolled or within 31 days of marriage, birth, or arrival in the U.S.

**Student Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 SUNY Campus \_\_\_\_\_ Student ID or Social Security # \_\_\_\_\_  
 Home Country \_\_\_\_\_  
 U.S. Mailing Address \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_  
 Telephone \_\_\_\_\_ Email \_\_\_\_\_  
 Birth Date: (mm/dd/yyyy) \_\_\_\_\_  Female  Male  Student  Scholar

**Dependent Information**

Name of Dependents: \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_\_\_  
 Spouse \_\_\_\_\_  Female  Male  
 Child \_\_\_\_\_  Female  Male  
 Child \_\_\_\_\_  Female  Male  
 Child \_\_\_\_\_  Female  Male

	Period of Coverage		Spouse		Children	Total
Annual	8/15/07 to 8/14/08	<input type="checkbox"/>	\$2,034.00	<input type="checkbox"/>	\$1,095.00	
Quarterly	8/15/07 to 11/14/08	<input type="checkbox"/>	\$508.50	<input type="checkbox"/>	\$273.75	
	11/15/07 to 2/14/08	<input type="checkbox"/>	\$508.50	<input type="checkbox"/>	\$273.75	
	2/15/08 to 5/14/08	<input type="checkbox"/>	\$508.50	<input type="checkbox"/>	\$273.75	
	5/15/08 to 8/14/08	<input type="checkbox"/>	\$508.50	<input type="checkbox"/>	\$273.75	
Monthly* (or fraction of)		<input type="checkbox"/>	\$169.50	<input type="checkbox"/>	\$91.25	

Begin Coverage on \_\_\_/\_\_\_/\_\_\_ and continue for \_\_\_ months      Monthly premium \$ \_\_\_\_\_ x # of months \_\_\_\_\_ = \_\_\_\_\_

\* Available only when a term of less than three months is required, or in order to provide coverage for dependents arriving prior to the beginning of a term. Coverage cannot extend past 8/14/08.

Make checks payable to **HTH Worldwide Insurance Services** and mail with enrollment form to HTH Worldwide Insurance Services, One Radnor Corporate Center, Suite 100, Radnor, PA 19087. REMITTANCE IN U.S. FUNDS ONLY.

I understand that expenses incurred by my dependents for conditions for which they receive treatment for medical advice, or had symptoms, prior to effective date of coverage, may not be covered until they have been enrolled in the plan for 6 continuous months.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

*Reminder for Dependents: Please enclose a photocopy of your I-94. This is required by the Insurance Company*

Verification: I verify that the above applicant(s) is/are dependent(s) of \_\_\_\_\_  
 an international student duly enrolled in the SUNY International Student & Scholar Insurance Program.

Verified by: (name & title, i.e. FSA) \_\_\_\_\_ Date \_\_\_\_\_