

Miami University – Study Abroad GROUP HEALTH INSURANCE ENROLLMENT FORM

PLEASE PRINT – ANSWER ALL QUESTIONS. YOUR APPLICATION WILL BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED. **ENROLL ONLINE USING GROUP ENROLLMENT CODE: CNX-4745**

PERSONAL INFORMATION

Name of Participant: _____ **Gender:** M F **Date of Birth:** _____
(First Name) (Middle Name) (Last Name) MM DD YYYY

Mailing Address: _____
(Street) (Room/Apt. #) (City) (State) (Zip Code)

Home Phone: _____ **Mobile Phone:** _____ **Email Address:** _____

What is your Home Country?: _____ **Student ID:** _____

COVERAGE INFORMATION

I WISH TO ENROLL FOR INSURANCE UNDER THE TERMS OF THE MASTER POLICY AS FOLLOWS:

Coverage Type: Participant Only Participant & Spouse Participant & Child(ren) Participant & Family

I want my coverage to begin on _____ and to end on _____
MM DD YYYY MM DD YYYY

Weekly Rates:	Participant	Spouse	Child	Children
Up to Age 49	\$11.00	\$44.00	\$16.25	\$32.50
Ages 50-64	\$44.00	\$132.00	\$16.25	\$32.50

Valid 9/1/08 – 8/31/09

Premium for Participant	\$ _____
Premium for Spouse	\$ _____
Premium for Child(ren)	\$ _____
Multiply by Weeks of Coverage	x _____
Total Premium Enclosed:	\$ _____

Names of Spouse and Children to be insured, if applicable*

	Gender	Date of Birth
Spouse: _____ <small>(First Name) (Last Name)</small>	<input type="checkbox"/> M <input type="checkbox"/> F	_____ <small>MM DD YYYY</small>
Child: _____ <small>(First Name) (Last Name)</small>	<input type="checkbox"/> M <input type="checkbox"/> F	_____ <small>MM DD YYYY</small>
Child: _____ <small>(First Name) (Last Name)</small>	<input type="checkbox"/> M <input type="checkbox"/> F	_____ <small>MM DD YYYY</small>
Child: _____ <small>(First Name) (Last Name)</small>	<input type="checkbox"/> M <input type="checkbox"/> F	_____ <small>MM DD YYYY</small>
Child: _____ <small>(First Name) (Last Name)</small>	<input type="checkbox"/> M <input type="checkbox"/> F	_____ <small>MM DD YYYY</small>

***Please Note: Dependent coverage is available only when the student first applies for insurance or within 31 days of marriage, the birth of a child or a dependents arrival in the United States.**

Beneficiary Information for Accidental Death & Dismemberment Coverage

Participant's Beneficiary*: _____
(Name and Relationship)

***Note:** The Participant will be the beneficiary for any insured dependent's loss of life

PAYMENT INFORMATION

REMITTANCES ACCEPTED IN U.S. FUNDS ONLY

METHOD OF PAYMENT: Check Money Order Credit Cards: MasterCard VISA American Express Discover
 If paying by credit card, I authorize HTH Worldwide to bill my account for the Total Premium listed above

CARD#: _____ **EXP. DATE:** _____

Name as it appears on card: _____ **(Signature of Cardholder if different from Participant)** _____

I certify that the information on this Enrollment Form is true and correct to the best of my knowledge. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signature of Participant: _____ **Date** _____

Make checks payable to "HTH Worldwide Insurance Services" and mail with this completed enrollment form to:
 HTH Worldwide Insurance Services, One Radnor Corporate Center, Suite 100, Radnor, PA 19087

If paying by Credit Card, Fax to 1.866.281.1643. The coverage will be effective at 12:01 A.M. on the day which is at least 24 hours after the time and date of the receipt of the enrollment form.