

Miami University, Ohio
GROUP HEALTH INSURANCE ENROLLMENT FORM

PLEASE PRINT – ANSWER ALL QUESTIONS. YOUR APPLICATION WILL BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.

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	\$10.50	\$42.00	\$15.75	\$31.50	Premium for Participant	\$ _____
Ages 50-64	\$42.00	\$126.00	\$15.75	\$31.50	Premium for Spouse	\$ _____
Valid 9/1/05 – 8/31/06					Premium for Child(ren)	\$ _____
					Multiply by Whole Months of Coverage	x _____
					Total Premium Enclosed:	\$ _____

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

Spouse: _____ M F _____
 (First Name) (Last Name) MM DD YYYY

Child: _____ M F _____
 (First Name) (Last Name) MM DD YYYY

Child: _____ M F _____
 (First Name) (Last Name) MM DD YYYY

Child: _____ M F _____
 (First Name) (Last Name) MM DD YYYY

Child: _____ M F _____
 (First Name) (Last Name) MM DD YYYY

*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.