

UNICARE®
LIFE & HEALTH INSURANCE COMPANY
DEPENDENT Medical Insurance Enrollment Form
2007-2008

GRADUATE ASSISTANTS
ONLY

1. Student Information				
Name of Group Florida International University		Group Number 131068		Network Name/ID PHSFL
LAST NAME (Family)		FIU-Panther ID Number		FIU Department
FIRST NAME (Given)	MI	Email Address		
USA Street Address	Apt. #	Telephone Number	Cell Phone Number	
City/State/Zip Code		Date of Birth (Mo/Day/Yr)	GENDER M-Male F-Female M <input type="checkbox"/> F <input type="checkbox"/>	

2. Covered Dependent Information				
	NAME (Last, First, MI)	SEX M -Male F - Female	DATE OF BIRTH (Mo/Day/Yr)	FULL TIME STUDENT (if 19 or older)
Spouse		M <input type="checkbox"/> F <input type="checkbox"/>		
Child		M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Rates- The rates below provide coverage for any period between August 20, 2007 and August 19, 2008

PLEASE INDICATE COVERAGE SELECTION BY MARKING THE APPROPRIATE BOX:

	Semi-Annual Premium	
Spouse	\$2122.00	<input type="checkbox"/>
Child(ren)	\$1101.00	<input type="checkbox"/>
Spouse & Child(ren)	\$3226.00	<input type="checkbox"/>

METHOD OF PAYMENT (U.S. Funds ONLY)

Cashier's Check Money Order

Payment Date ____/____/____

IMPORTANT

To enroll your dependents, please mail a cashier's check or money order payable to UNICARE LIFE & HEALTH INSURANCE COMPANY to P.O. Box 52207 Durham, NC 27717.

Note:
Student will be billed the 2nd Semi-Annual dependent premium in October.

Will any covered dependent have 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, you will be receiving a short questionnaire to complete.

Graduate Assistant Authorization

I am a Graduate Assistant attending Florida International University and wish to enroll my dependents in the insurance program under the terms of the Master Policy, which I acknowledge are as follows: 1.) my dependents may be insured if I am insured under this plan; 2.) my dependents may enroll on the same date of my enrollment or within 31 days of arrival in the United States of America, of the date of birth, or of the date of marriage to me; 3.) 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;; 4.) I also understand my dependents are eligible for coverage only during the time I am insured.

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.

STUDENT'S SIGNATURE _____ TODAY'S DATE _____

