ADELPHI UNIVERSITY – Policy # CHH0084932 / ENHANCED PLAN – OPTION II

STUDENT ACCIDENT & SICKNESS INSURANCE VOLUNTARY ENROLLMENT FORM FOR ALL REGISTERED STUDENTS – 2011-2012

Student Name (Print) _____
(Last) (First) (M.I.)

Student Identification Number (**required**)_____ Date of Birth _____Male _____ Female _____

Home Address (Print) _____
(Number and Street) (City) (State) (Zip Code)

I have read, understand, and agree to the terms and conditions of the insurance coverage as described in the brochure. I am covered under the Basic Accident Plan and elect to purchase the Enhanced Accident and Sickness Plan (Option II) as indicated below. Coverage begins at 12:01 a.m. on the effective date of the coverage term selected below, or on the day after the date this form and payment are received, if later, and terminates on the earlier of a) the date the Policy terminates; b) the last day for which premium has been paid, or c) the date the Covered Person enters the armed forces. Covered Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made to such persons upon written request received by the Company. No other refunds of premiums will be allowed.

I understand that if elected, OPTION II – Enhanced Plan replaces OPTION I.

	ANNUAL	SPRING (Only available to new students to the University)
COVERAGE DATES	8/15/11* to 8/15/12	01/01/12 to 8/15/12
OPTION II – ENHANCED ACCIDENT & SICKNESS PLAN	$1,200 ___	$804 ___
Deadline to Enroll (No form will be accepted after the deadline)	10/15/11	3/15/12

*8/10/11 for NEW International students. PLEASE CHECK THE APPROPRIATE BOX: ☐ Domestic Student ☐ International Student

PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO: *Adelphi University Student Insurance*

PLEASE RETURN THIS FORM WITH PAYMENT TO: Adelphi University, Health Services Center, One South Avenue, PO Box 701, Garden City, NY 11530-0701
IF PAYING BY CREDIT CARD, YOU MUST GO TO THE CASHIER'S OFFICE IN THE LOWER LEVEL OF LEVERMORE HALL TO MAKE PAYMENT. RETURN THIS FORM AND THE ACCOUNT RECEIPT TO HEALTH SERVICES CENTER, WALDO HALL.

Signature _____ **Date** _____