DEPENDENT MEDICAL INSURANCE ENROLLMENT FORM 2016-2017

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	# of Months	Total
Inbound	8/15/2016 - 8/14/2017	Monthly	⊂ $233.31	⊂ $124.89	x	$
		16-Day Rate	⊂ $127.54	⊂ $68.50	x	$
Outbound	8/15/2016 - 8/14/2017	Monthly	⊂ $233.31	⊂ $124.89	x	$
		16-Day Rate	⊂ $127.54	⊂ $68.50	x	$
Total						$
Start Date ____/_____/_____ Number of Months _____						

Make checks payable to ***Worldwide Insurance Services*** and mail with enrollment form to 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/Scholar _____ 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 _____