

FLORIDA ATLANTIC UNIVERSITY STUDENT HEALTH PLAN DOMESTIC GRADUATE ASSISTANTS

Underwritten by UNITEDHEALTHCARE

Policy# 2025-34-A

PLEASE PRINT CLEARLY – FAILURE TO PROVIDE ALL INFORMATION MAY DELAY OR VOID YOUR INSURANCE

Student's Last Name: _____ Middle Initial: _____

First Name: _____

Student I.D #: _____ [] Male [] Female Date of Birth (Month/Day/Year): _____

U.S.A Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #:(_____) Email Address: _____

DEPENDENTS – Complete information below if you are including dependents

NOTE: Dependent coverage is available only for students insured under this plan. Coverage must be purchased at the time of the primary insured's enrollment or within 30 days of birth/marriage or arrival in country and must match the student's enrollment period.

Spouse Last Name: _____ First Name: _____

Date of Birth (month/day/year): ____/____/____ Gender [] Male [] Female Visa Type: [] F1 [] M1 [] J1 Other: _____

CHILD 1 Last Name _____ First Name: _____

Date of Birth (month/day/year): ____/____/____ Gender [] Male [] Female Visa Type: [] F1 [] M1 [] J1 Other: _____

CHILD 2 Last Name _____ First Name: _____

Date of Birth (month/day/year): ____/____/____ Gender [] Male [] Female Visa Type: [] F1 [] M1 [] J1 Other: _____

PREMIUM- (Please check appropriate box)

FALL	SPRING:	SUMMER
8/14/25 to 12/31/25	1/1/26 to 5/7/26	5/8/26 to 8/13/26

DEPENDENT(S):		
Spouse	<input type="checkbox"/> \$ 3,577.00	<input type="checkbox"/> \$ 3,245.00 <input type="checkbox"/> \$ 2,504.00
Each Child	<input type="checkbox"/> \$ 3,577.00	<input type="checkbox"/> \$ 3,245.00 <input type="checkbox"/> \$ 2,504.00
All Children:	<input type="checkbox"/> \$ 7,154.00	<input type="checkbox"/> \$ 6,490.00 <input type="checkbox"/> \$ 5,008.00

METHOD OF PAYMENT:

CHECK MONEY ORDER (Make payable to Insurance for Students, Inc.) Credit Card/Debit Card

TOTAL PREMIUM NOW DUE: \$ _____

Please complete below if paying by credit card/debit card and include a 4% processing fee for credit & debit card payments

IMPORTANT: If paying by credit card a link will be emailed to you from accounting@insuranceforstudents.com allowing you to submit your credit payment via a secure PCI compliant web portal.

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) They have carefully read the brochure and elect to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) They meet the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. **PREMIUM WILL NOT BE REFUNDED EXCEPT FOR INELIGIBILITY OR ENTRANCE INTO THE ARMED FORCES.**

I understand that I must be an enrolled and eligible student in the FAU Graduate College to enroll dependents in this coverage.

Student's Signature: _____ Date: _____

FOR CREDIT & DEBIT CARD PAYMENTS PLEASE EMAIL COMPLETED FORM TO INFO@INSURANCEFORSTUDENTS.COM
PAYMENTS BY CHECK OR MONEY ORDER MUST BE MAILED ALONG WITH THE COMPLETED FORM TO:
INSURANCE FOR STUDENTS INC. – 1690 S. CONGRESS AVE #101, DELRAY BEACH FL 33445
PHONE: (800) 356-1235 FAX: (954) 772-0872