FLORIDA ATLANTIC UNIVERSITY STUDENT HEALTH PLAN
COLLEGE OF MEDICINE & COLLEGE OF NURSING STUDENTS
Underwritten by UNITEDHEALTHCARE Policy# 2022-34-2

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)

Please select College: **College of Medicine** ☐ **College of Nursing** ☐

	SPRING/SUMMER: 1/1/23 to 8/13/23	**SUMMER: 5/10/23 to 8/13/23**
Student	☐ $ 1,217.00	☐ $ 520.00
DEPENDENT(S):		
Spouse	☐ $ 4,751.00	☐ $ 2,027.00
Each Child	☐ $ 4,751.00	☐ $ 2,027.00
All Children:	☐ $ 9,502.00	☐ $ 4,054.00

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

Credit Card/Debit Authorization – [ ] MasterCard [ ] Discover [ ] American Express [ ] Visa Please bill my card for my insurance premium shown above

Cardholder Name: (Last/First) _____

Cardholder Number: _____ Expiration Date (month/year):____/____ CVC:_____

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 student in the FAU College of Medicine or FAU College of Nursing program to enroll 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