Vanderbilt Student Injury and Sickness Insurance Plan
2008-2009 Policy Year Dependent Enrollment Form

(Please Print)

Student Name_____ **9 digit ID#**_____
Last First Middle Initial

Permanent US Address_____
Street/PO Box City State Zip Code

Date of Birth _____ **Gender**_____ **Undergraduate / Graduate**
mm/dd/yyyy

Phone Number_____ **Email Address**_____

Charge to my (check one): __ Visa __ Master Card __ Check or money order (International checks are not accepted)

Card Number:_____ Amount Charged: $_____ Expiration Date:_____

Print Name and Address of Card holder_____

Make Payment to **Gallagher Koster** and either mail to PO Box 845663, Boston, MA 02284-5663 or return it to the On-Campus Student Insurance Representative located at the Student Health Center. You must be eligible to enroll in the Plan and meet the enrollment deadline in order for your enrollment to be accepted by us. It is the Insured Student's responsibility for the timely enrollment of all eligible dependents each year. If the deadline is not met, the effective date will be the postmark date on the envelope and no pro-rate of premium is available.

Please check only one enrollment period: Annual_____ Spring Semester_____ May Mester_____ Summer Term _____

Undergraduate	**Annual Policy**	**Spring Semester**	**May Mester**	**Summer Term**
	8/12/08 - 8/11/09	1/1/09 - 8/11/09	5/01/09 - 8/11/09	6/1/09 - 8/11/09
Application Deadline	**9/20/08**	**2/01/09**	**6/01/09**	**7/01/09**
Spouse/Domestic Partner	$866.00	$544.00	$272.00	$197.00
All Children	$683.00	$429.00	$215.00	$157.00
Graduate/International	**Annual Policy**	**Spring Semester**	**May Mester**	**Summer Term**
	8/12/08 - 8/11/09	1/1/09 - 8/11/09	5/01/09 - 8/11/09	6/1/09 - 8/11/09
Application Deadline	**9/20/08**	**2/01/09**	**6/01/09**	**7/01/09**
Spouse/Domestic Partner	$2,498.00	$1,559.00	$723.00	$507.00
Child(ren)	$1,568.00	$979.00	$455.00	$319.00

List Dependent(s) to be insured below. Dependent coverage is available only when the student is also insured under this plan and cannot exceed coverage purchased by the student. Dependents need to be enrolled within 30 days from the effective date for the period of coverage selected. In the event of a qualifying event (i.e. birth of child, marriage, etc.), this Dependent Enrollment form and payment must be received by Gallagher Koster within 31 days of the qualifying event.

Dependent Information	**Last Name**	**First Name**	**MI**	**Date of Birth**	**Gender**
Spouse:					
Child:					
Child:					
Child:					

Notice to Students:
Coverage will be effective the date of the policy period selected, when submitted by the printed deadline or within 31 days of the qualifying event and the correct premium is received by Gallagher Koster. It is the student's responsibility for timely renewal payment. By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment form. 2) Rates are not prorated other than as listed on this enrollment form. 3) He/She meets the eligibility requirements for this coverage as described in the brochure. 4) If it is later determined that the student is not eligible, the premium will be refunded. 5) A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Injury and Sickness Insurance Plan. 6) Other than for eligibility reasons, the premium is not refundable.

Signature of Student:_____Date:_____

PAYMENT INSTRUCTIONS: Make check or money order payable to **Gallagher Koster.**. Mail enrollment form along with premium payment to: **Gallagher Koster, PO Box 845663, Boston MA 02284-5663, 1-800-468-5867** or return it to the On-Campus Student Insurance Representative located at the Student Health Center.

You must be eligible to enroll in the Plan and meet the enrollment deadline in order for your enrollment to be accepted by us. If it is discovered that you do not meet the requirements, your premium will be refunded.