



**Vanderbilt University
Medical Evacuation and Repatriation of Remains Benefits
2008-2009 Policy Year Enrollment Form**

Name _____ Student ID# _____
Last First M

Date of Birth _____ Male _____ Female _____ Telephone No. _____ Email: _____
MM/DD/YY (Please check)

US Mailing Address _____
PO Box or Street Address (include Apt or Unit#) City State Zip Code

List dependents to be insured below. Dependent coverage is available only if the insured is enrolled in the Vanderbilt University Accident and Sickness Insurance Plan. Dependent coverage expires concurrently with that of the Insured Student.

	Name	Gender	Date of Birth
Spouse/Domestic Partner _____	<small>Last First MI</small>	_____	_____
Child _____	<small>Last First MI</small>	_____	_____
Child _____	<small>Last First MI</small>	_____	_____
Child _____	<small>Last First MI</small>	_____	_____

By signing below, I acknowledge the following: 1) I have read the brochure and elect to enroll as indicated. 2) Rates are not pro-rated. 3) I permit Vanderbilt University to provide Gallagher Koster. with my student status for purpose of eligibility under this plan. 4) I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage, and coverage for my spouse and child(ren) may be made void. 5) I understand that if it is later determined that I am not eligible, the premium will be refunded, and any claims paid will be solely my responsibility but the premium is not refundable for reasons other than eligibility.

Signature _____ Date _____

Desired Coverage: Coverage will be effective the date the correct premium is received by Gallagher Koster or the Insurance Representative on campus. It is the insured's responsibility for timely renewal payment.

RATES/COVERAGE

The cost of the Scholastic Emergency Services program is \$61.00 per person. This coverage provides a \$25,000 Medical Evacuation benefit, \$10,000 Repatriation of Remains benefit, 24-hour travelers' assistance and Accident Death and Dismemberment coverage up to a \$10,000 maximum. These benefits must be approved in advanced by the Company.

My remittance in the amount of \$_____ is enclosed. I am paying by:

_____ Check: Make check or money order payable to **Gallagher Koster**

_____ Credit Card: MasterCard or Visa number _____ Exp. Date _____

Signature of Cardholder _____

Submit Application, payment and direct inquiries to:

Gallagher Koster.
 PO Box 845663
 Boston, MA 02284-5663

Phone: 1-800-468-5867 **Fax:** 1-617-479-0860, or return it to the On-Campus insurance representative located at the Vanderbilt University Student Health Center.