

Vanderbilt University Optional Supplemental Coverage 2008-2009 Year Enrollment Form

(Please Print)

Student Name _____
Last
First
Middle Initial

Permanent US Address _____
Street or P.O.Box
City
State
Zip Code

Student ID# _____ Male _____ Female _____ Date of Birth _____
mm/dd/yyyy

Phone Number _____ Email Address _____

OPTIONAL SUPPLEMENTAL ACCIDENT AND SICKNESS INSURANCE PLAN - ANNUAL RATES

UNDERGRADUATE	
Student Under 35	\$ 364.00
Student 35 or Over	\$ 471.00
Spouse/Domestic Partner under 35	\$ 536.00
Spouse/Domestic Partner over 35	\$ 699.00
Each Child	\$ 288.00

GRADUATE	
Student Under 35	\$ 370.00
Student 35 or Over	\$ 480.00
Spouse/Domestic Partner under 35	\$ 545.00
Spouse/Domestic Partner over 35	\$ 708.00
Each Child	\$ 290.00

The Deadline to Enroll is August 20, 2008 for coverage to be effective at the beginning of the coverage period.

Lifetime Plan Maximum: \$500,000
 \$50,000 deductible for Undergraduate and \$100,000 deductible for Graduate/International
 \$100,000 Lifetime Maximum per Insured Dependent

Dependent Information:

In order for Dependents to be enrolled, they must be enrolled under the Student Injury and Sickness Insurance Plan. Dependent coverage expires concurrently with that of the Insured Student.

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

Notice to Students:

For forms submitted by the deadline, coverage will be effective date of the coverage period. Forms will not be accepted after the deadline. 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 Optional Supplemental coverage 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) Other than eligibility, the premium is not refundable.

Signature of Student: _____ Date: _____

PAYMENT INSTRUCTIONS:

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

___ Check: Make check or money order payable to **Gallagher Koster**
 Mail enrollment form along with premium payment to:

Gallagher Koster
P.O. Box 845663
Boston, MA 02284-5663
1-800-468-5867 / 1-617-769-5867
www.gallagherkoster.com

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.