

2007-2008 SABA University, School of Medicine, Clinical Accident & Sickness Plan

VOLUNTARY ENROLLMENT FORM ACCIDENT AND SICKNESS INSURANCE PLAN

POLICY GLMN01060788

ACE American Insurance Company , Philadelphia, PA 19106

Student's Name (Last) _____ (First) _____ (MI) _____

Permanent Address

Street _____

City/State/Zip _____ Home Telephone _____ Student's Date of Birth _____ email address _____

Male ___ Female ___ Your Beneficiary _____ Relationship _____

Effective date of coverage to begin (date) _____

Length of coverage applied for _____

NAMES OF DEPENDENTS FOR WHICH PREMIUM IS ENCLOSED -Student must be insured in order to enroll his or her eligible dependents

Dependent Name	Relationship to Student	Sex (M/F)	Date of Birth (Month/Day/Year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I understand that a refund of premium (less a \$10.00 processing fee) will be considered only if a written request is received by CMI Insurance prior to the effective date of coverage. After that date all premium is considered fully earned and non-refundable. Partial refunds are not available. I further understand that credit card payments will be subject to a \$7.00 administrative fee. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. I have read the brochure and elect to enroll myself and (if applicable) my dependents as shown above. Please sign on the line below.

Signature _____ Date _____

To apply, complete this Voluntary Enrollment Form and return it to CMI Insurance, 1447 York Rd, Lutherville, MD 21093 phone 410-583-2595, FAX 410-583-8244 with a check or money order for the premium (in U.S. dollars and drawn on a U.S. Bank or U.S. Bank affiliate) payable to ACE American Insurance Company. The correct premium must be submitted for the full period of coverage requested on this Voluntary Enrollment Form. Coverage will be effective on the date requested or the date premium is received, whichever is later. Or, apply on line at www.cmi-insurance.com

Rates	9/1/07-1/1/08	1/1/08-5/1/08	5/1/08-9/1/08
Student:	\$ 662.00	\$ 662.00	\$ 662.00
Dependents			
Spouse (Additional)	\$1,265.00	\$1,265.00	\$1,265.00
Each Child (Additional)	\$ 942.00	\$ 942.00	\$ 942.00

Total applied for _____

PAYMENT METHOD (U.S. Funds only): Check, Money Order, MasterCard/Visa Card # _____ - _____ - _____ - _____ Exp. Date ____ / ____

I understand that credit card payments will be subject to a \$7.00 administrative fee.