

**AMERICAN UNIVERSITY IN CAIRO  
2011 - 2012**

**Policy GLMN 01173662**

**Underwritten By: ACE American Insurance Company, Philadelphia Pennsylvania**

**Enrollment Form for Dependents' Coverage (Please Print or Type)**

Student' Last Name                      First Name                      Middle Initial

Street – Permanent Mailing Address

City    State    Country    Code

I wish to enroll my Eligible Dependents, named below, for coverage under the Plan. Please refer to your American University in Cairo plan for a summary of the coverage available to Eligible Dependents.

I understand that insurance becomes effective only when this Enrollment Form and full premium payment have been received by CMI Insurance at the address shown below.

Student's Signature

Date

Mark the appropriate boxes

Monthly Premium

- |  |          |
|--|----------|
| <input type="checkbox"/> Spouse less than age 25 | \$ 54.00 |
| <input type="checkbox"/> Spouse age 25 – 34      | \$ 72.00 |
| <input type="checkbox"/> Spouse age 35 – 49      | \$ 89.00 |
| <input type="checkbox"/> Spouse age 50 – 64      | \$114.00 |
| <input type="checkbox"/> Spouse age 65 and over  | \$144.00 |
| <input type="checkbox"/> One Child               | \$ 48.00 |
| <input type="checkbox"/> Two or More Children    | \$ 93.00 |

Total Monthly Premium: \$ \_\_\_\_\_  
Number of Months X \_\_\_\_\_

**Total Premium Due** \$ \_\_\_\_\_

Dependents' coverage will become effective and terminate on the same dates as the Student, provided the required premium is paid. Indicate the requested effective date for the dependent(s). Termination of coverage must coincide with the student's termination of coverage.

Effective Date: \_\_\_\_\_ Termination Date: \_\_\_\_\_

I wish to extend my own coverage to include my following dependents (spouse and/or unmarried children under age 19)

<b>Dependent's Name</b>	<b>SS #</b>	<b>Date of Birth</b>	<b>Relationship to Student</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**My signature below certifies that I have read and understand the brochure and agree to accept the terms and conditions stated therein.**

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Make Check or Money Order Payable To: MEDEX Insurance Services  
Send Payment and This Form To: CMI Insurance, FrontierMEDEX, P.O. Box 19056, Baltimore, MD 21284**