PLEASE COMPLETE THIS FORM IN BLOCK LETTER PRINT USE BLACK INK

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES 2005-5338-1/2

SOCIAL SECURITY # _______-_____-___________ **or** SCHOOL ID# ____________________

PRIMARY INSURED STUDENT NAME: ____
Last (Family) Name

____
First (Given) Name Middle Initial

GENDER: ❑ Male ❑ Female (Check one) DATE OF BIRTH: ______ - ____ - ______ (Month Day Year) EXPECTED DATE OF GRADUATION: ______ - ______ (Month Year)

PERMANENT ADDRESS: ____
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route | City | County | State | ZIP - Code

MAILING ADDRESS: ____
House/Building Number and Street Name

Apt. or P.O. Box # or Rural Route | City | County | State | ZIP - Code

TELEPHONE # ______-______-__________ E-MAIL ADDRESS: ______________________________

Complete information below for Dependents to be insured. Dependent coverage is available only for Dependents of Students insured under the Plan.

SPOUSE: ____-____-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: ____-____-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: ____-____-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: ____-____-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

CHILD: ____-____-________ (Social Security Number) ❑ Male ❑ Female (Check One) Date of Birth: ______-______-______ (Month Day Year)

First (Given) Name | M/I | Last (Family) Name

NOTICE TO STUDENT: Coverage will be effective the date the enrollment is received by the Company or the Effective Date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces**.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: ______________________________ DATE: ______________________

02-NRL

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES **2005-5338-1/2**

CAMPUS/SCHOOL ATTENDING: University of Arkansas for Medical Sciences

Please Print Name of College or University Must be completed in order for application to be processed.

❑ **I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.**

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY: ❑ **Regular Students - Policy # 2005-5338-1**

	Annual (A-)	**Fall (F-)**	**Spring (G-)**	**Summer (S-)**
A. Student	❑ $1731.00	❑ $ 737.00	❑ $ 635.00	❑ $393.00
B. Spouse	❑ $4237.00	❑ $1805.00	❑ $1555.00	❑ $962.00
C. All Children	❑ $2809.00	❑ $1196.00	❑ $1031.00	❑ $638.00

EFFECTIVE / EXPIRATION PERIODS:

Periods:		
	Annual	❑ 08-11-2005 to 08-10-2006
	Fall	❑ 08-11-2005 to 01-10-2006
	Spring	❑ 01-10-2006 to 05-21-2006
	Summer	❑ 05-21-2006 to 08-10-2006

INSURED CATEGORY: ❑ **Other: Jr. & Sr. Medical Students and Sr. Pharmacy Students - Policy # 2005-5338-2**

	Annual (A-)	**Semi-Annual (IX)**
D. Student	❑ $1731.00	❑ $ 883.00
E. Spouse	❑ $4237.00	❑ $2161.00
F. All Children	❑ $2809.00	❑ $1433.00

EFFECTIVE / EXPIRATION PERIODS:

Periods:		
	Annual	❑ 07-02-2005 to 07-01-2006
	1st Semi Annual	❑ 07-02-2005 to 01-02-2006
	2nd Semi-Annual	❑ 01-02-2006 to 07-01-2006

Payment Instructions: Make check or money order payable to Student Insurance in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to Student Insurance, PO Box 809026, Dallas TX 75380-9026. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT $ ____________ ❑ VISA or ❑ MASTERCARD # ________________________

Expiration Date ____ - ____ Month Year

AUTHORIZED SIGNATURE ________________________ DATE ________________

OR PAID BY CHECK # ________________ AMOUNT PAID $ __________ . ______