Tompkins Cortland Community College – Dependent Form

Academic Year 2009 - 2010

DEPENDENT HEALTH INSURANCE ENROLLMENT FORM

PLEASE PRINT CLEARLY - ANSWER ALL QUESTIONS

STUDENT'S FIRST NAME

STUDENT'S LAST NAME

USA STREET ADDRESS **APARTMENT #**

CITY	State	Zip Code	TELEPHONE NO.

MALE ☐ FEMALE ☐	DATE OF BIRTH (MONTH/DAY/YR.):	HOME COUNTRY:
STUDENT ID #:	STUDENT'S HTH WORLDWIDE CERTIFICATE ID #:	
PREFERRED EMAIL ADDRESS:	EMERGENCY CONTACT NAME/ ADDRESS/ PHONE:	
ADVISOR NOTES:	ADDRESS IN HOME COUNTRY:	

IMPORTANT - DEPENDENT COVERAGE IS AVAILABLE ONLY WHEN THE STUDENT FIRST APPLIES FOR INSURANCE OR WITHIN 31 DAYS OF BIRTH, MARRIAGE OR ARRIVAL IN THE USA. DEPENDENTS MUST ENROLL WITHIN THE EFFECTIVE DATE RANGE OF THE STUDENT'S POLICY.

PREMIUM RATES: Rates valid from 8/1/09 - 7/31/2010	SPOUSE	ONE CHILD	CHILDREN
☐ MONTHLY	$291.00	$145.00	$290.00

EFFECTIVE DATE: _____ / _____ / _____ **TERMINATION DATE** _____/ _____/ _____

DEPENDENT INFORMATION (IF ENROLLED)

SPOUSE _____ F ☐ M ☐
LAST NAME FIRST NAME DATE OF BIRTH

CHILD _____ F ☐ M ☐
LAST NAME FIRST NAME DATE OF BIRTH

CHILD _____ F ☐ M ☐
LAST NAME FIRST NAME DATE OF BIRTH

CHILD _____ F ☐ M ☐
LAST NAME FIRST NAME DATE OF BIRTH

PREMIUM ENCLOSED FOR:

SPOUSE $_____

CHILD/ CHILDREN $_____

TOTAL PREMIUM $_____

MAKE CASHIER CHECK OR MONEY ORDER PAYABLE TO:
HTH WORLDWIDE

AND MAIL THIS FORM TO:
HTH WORLDWIDE
1 Radnor Corporate Center, Suite 100
Radnor, PA, 19087

STUDENT'S SIGNATURE DATE

REMITTANCE IN U.S. FUNDS ONLY

Credit Card Authorization: MasterCard ☐ VISA ☐ American Express ☐ Discover ☐

Card Number _____ **Expiration Date:**_____

Full Name of Cardholder: _____**Cardholder Signature:** _____

Cardholder Address:_____