STUDENT EDUCATIONAL BENEFIT TRUST

ENROLLMENT FOR VOLUNTARY STUDENTS AND THEIR DEPENDENTS

NOVA SOUTHEASTERN

2017 - 2018

CONTACT US:

1-877-233-5159 press 2 and 2

SERVICE@SEBTRUST.COM

PRIMARY INSURED - Complete information below for Student		
SOCIAL SECURITY #:	STUDENT ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR	EXPECTED DATE OF GRADUATION: _____/_____ MONTH YEAR
PERMANENT U.S. ADDRESS - House/Building Number and Street Name:		
CITY:	STATE	ZIPCODE
MAILING ADDRESS - House/Building Number and Street Name:		
CITY:	STATE	ZIPCODE
TELEPHONE #:	EMAIL ADDRESS:	
DEPENDENT INFORMATION: Complete information below for dependents to be insured. Dependent coverage is only available for Student insured under the Plan (Please include a blank sheet for additional Dependents).		
SPOUSE or DOMESTIC PARTNER SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
CHILD (1) SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
CHILD (2) SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
CHILD (3) SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
CHILD (4) SOCIAL SECURITY #:	GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: _____/_____/_____ MONTH DAY YEAR
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company of the effective date of the coverage period, whichever is later, unless otherwise stated in the Summary Plan Document (SPD). By signing, the student acknowledges the following: (1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment application" (2) Rates are not pro-rated other than as listed on this enrollment application; (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 premiums will be refunded. Premium will not be refunded for ineligibility or entrance into the Armed Forces.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal and/or civil penalties.

STUDENT's SIGNATURE: _____ DATE: _____

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CAMPUS / SCHOOL ATTENDING: _____

☐ I elect to purchase coverage under the University's Student Health Insurance Plan. Below are the choices that I have made:

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:

☐ Mandated Student ☐ Domestic

☐ Un-Mandated Student ☐ International

☐ Visiting Faculty / Scholar ☐ Student Athlete

MEDICAL ☐ YES ☐ OPT-OUT

PERIOD CODES	FALL (F)	SPR/SUM	ANNUAL	3 mo continuatio	monthly	less student
UNDERGRADUATE PLAN	8/11/2017 - 12/31/2017	1/01/2018 - 8/10/2018	8/1/17-7/31/18	GRADUATING STUDENTS	QE ONLY	
Student	☐ $795	☐ $795	☐ $1,590	☐ $632.03	$132.50	
Student + Spouse	☐ $1,950	☐ $1,950	☐ $3,900	☐ $1,550.25	$325.00	$192.50
Student + Child	☐ $1,305	☐ $1,305	☐ $2,610	☐ $1,037.48	$217.50	$85.00
Family	☐ $4,205	☐ $4,205	☐ $8,410	☐ $3,342.98	$700.83	$568.33
GRADUATE PLAN						
Student	☐ $1,025	☐ $1,025	☐ $2,050	☐ $814.88	$170.83	
Student + Spouse	☐ $2,525	☐ $2,525	☐ $5,050	☐ $2,007.38	$420.83	$250.00
Student + Children	☐ $1,685	☐ $1,685	☐ $3,370	☐ $1,339.58	$280.83	$110.00
Family	☐ $5,460	☐ $5,460	☐ $10,920	☐ $4,340.70	$910.00	$739.17

VISION ☐ YES

PERIOD CODES	ANNUAL*
Student Only	☐ $72.00
Student & Child(ren)	☐ $156.00
Student & Spouse	☐ $231.00
Student & Family	☐ $341.00

Please NOTE Dental and Vision can not be prorated

DENTAL ☐ YES

PERIOD CODES	ANNUAL*
Student Only	☐ $240.48
Student + 1	☐ $487.32
Student + 2	☐ $1,263.36

SHORT TERM COVERAGE CALCULATION (This section only applies to Traveling Faculty/Scholars)

Effective Date of Coverage _____/_____/_____ (MONTH / DAY / YEAR)		Termination Date of Coverage _____/_____/_____ (MONTH / DAY / YEAR)	
Number of Days with Coverage		Cost Per Day of Coverage	

STUDENT's SIGNATURE: _____ DATE: _____

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CAMPUS / SCHOOL ATTENDING: _____

QUALIFYING EVENT(s):

- ☐ Student and dependent(s) are eligible for coverage without a qualifying event
- ☐ Student is starting classes in the middle of the Fall, Spring or Summer Term
- ☐ Student or dependent was covered under COBRA continuation coverage and such coverage was exhausted
- ☐ Student or dependent lost, or will lose, eligibility for other coverage due to death, divorce, legal separation, termination of employment or termination of the employer contributions for the coverage, termination of employment in a class eligible for coverage, or reduction in hours of employment resulting in a loss of coverage.
- ☐ The Student no longer, or will no longer, live or work in a health plan's service area (and there is no other coverage available under the plan), or the plan no longer offers coverage to a class of similar individuals , which are inclusive of students and/or dependents.
- ☐ Student or dependent qualifies, or will qualify, under the standard events that are defined and set forth by HIPAA.
- ☐ Student is actively engaged in completing classes from the prior semester due to incompletes that were approved by the University

IT IS UNDERSTOOD THAT ANY ENROLLMENT THAT QUALIFIES FOR COVERAGE UNDER A QUALIFYING EVENT MUST BE SUPPORTED BY DOCUMENTATION OF THE TERMINATION OF THE OTHER COVERAGE WITH THE EFFECTIVE DATE OF SAID TERMINATION STATED AND APPROVED BY THE UNIVERSITY, OR AN AUTHORIZED REPRESENTATIVE OF THE UNVERSITY. NOTICE OF THE ABOVE EVENTS MUST BE PROVIDED TO THE UNIVERSITY WITHIN 31 DAYS OF THE OCCURENCE OF THE EVENT. IF TIMELY NOTICE IS NOT PROVIDED, THE STUDENT WILL BE REQUIRED TO WAIT UNTIL THE FOLLOWING TERM TO ENROLL.

AUTHORIZED REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

PAYMENT INFORMATION

CREDIT CARD AUTHORIZATION - Please be sure to print clearly (VISA and MasterCard are the only credit cards accepted by the Trust.)

☐ VISA ☐ MASTERCARD

Charges by Line of Coverage - Subtotals:

Medical $_____ Short Term[1] $_____

Vision $_____ Full Charge Amount $_____

Dental $_____

[1] **Restricted to Traveling Faculty / Scholars**

Prorated Monthly Rates (Plan I):[2]

Months until next AP _____

Monthly Rates

Total Charge for Remainder of AP

[2] **Restricted to Qualfiying events only / 15 of the Month Rule applies**

LAST NAME ON CARD:	FIRST NAME ON CARD:		MIDDLE INITIAL:
CREDIT CARD NUMBER: _____/_____/_____/_____	CVS #: #_____	EXPIRATION DATE: _____/_____	
CARD HOLDER SIGNATURE:			
BILLING ADDRESS - House/Building Number and Street Name:			
CITY:	STATE		ZIPCODE
TELEPHONE #:	EMAIL ADDRESS:		

APPLICATIONS MUST BE APPROVED AND SUBMITTED BY NOVA SOUTHEASTERN LIASION

STUDENT's SIGNATURE: _____ DATE: _____