BROWN UNIVERSITY
2009-2010 DEPENDENT ENROLLMENT FORM

I. STUDENT INFORMATION

Student's Name:_________________________________ Brown Banner ID ________________ Birth Date:__________
Last First Middle Initial mm/dd/yyyy

Address:_____________________________________ Telephone # (___)_________ Email:_______________________
Campus Box # City State Zip Code

II. DEPENDENT INFORMATION

Please enroll my: Spouse/Domestic Partner____ Child(ren)____ Spouse/Domestic Partner & Child(ren)___

Dependent coverage is available only when the student is also insured under the Student Health Insurance Plan and cannot exceed coverage purchased by the student. Dependents are not eligible for services at Health Services or Psychological Services.

Name of Dependent (Last, First, Middle Initial)	Relationship to Student (Spouse/DP, Child)	Birth Date (mm/dd/yy)	Gender (M, F)

III. COVERAGE OPTIONS (please select):

A. Annual Coverage (effective 8/15/09-8/15/10) _____

	Full Payment	3 - Installment Payment Option		
Payment Due and Coverage Effective	Due by 9/15/09 8/15/09-8/15/10	1st Payment, Due by 9/15/09 8/15/09-12/14/09	2nd Payment, Due 12/15/09 12/15/09-4/14/10	3rd Payment, Due by 4/15/10 4/15/10-8/15/10
Spouse/Domestic Partner	$1,971.00	$657.00	$657.00	$657.00
Child(ren)	$1,971.00	$657.00	$657.00	$657.00
Spouse/DP & Child(ren)	$3,514.00	$1,171.34	$1,171.34	$1,171.34

B. Spring Term Coverage (effective 1/15/10-8/15/10) _____

	Full Payment	2 - Installment Payment Option	
Payment Due and Coverage Effective	Due by 2/15/10 1/15/10-8/15/10	1st Payment, Due by 2/15/10 1/15/10-4/14/10	2nd Payment, Due 4/15/10 4/15/10-8/15/10
Spouse/Domestic Partner	$1,169.00	$584.50	$584.50
Child(ren)	$1,169.00	$584.50	$584.50
Spouse/DP & Child(ren)	$2,084.00	$1,042.00	$1,042.00

These premiums are in addition to the premium that is charged to your student account. The first payment must be submitted with this application no later than 9/15/09 for annual coverage or 2/15/10 for spring coverage. Premiums are not prorated for enrollment forms received after the deadline.

IV. PAYMENT PROCESS AND ADDRESS

Make Checks Payable to Nationwide Life Insurance Company and send payment(s) to: University Health Plans One Batterymarch Park, Quincy, MA 02169 800-437-6448	**Credit Card Authorization** (only available when paying full amount, not available when paying by installment) **Charge Amount: $**_____________ **Visa**________ **Mastercard**_______ **Card #**___________________________________ **Exp. Date**___/_____ Signature of Cardholder_________________________ Date__________

Notice to Students:

By signing below, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll his/her dependents as indicated on this enrollment form; 2) Premiums are not pro-rated other than as listed on this enrollment form; 3) It is his/her responsibility for timely renewal payment; bills are not mailed. If future payments are not received by the due date, then coverage will be terminated as of the last date for which premium was received and dependents will not be eligible for coverage until the next policy year; 4) He/She meets the eligibility requirements for this coverage in the brochure; 5) If it is later determined that the student is not eligible, the premium will be refunded; 6) A Dependent cannot be insured under this Plan if the Insured Student loses eligibility under the Student Health Insurance Plan; 7) Other than for eligibility reasons, the premium is not refundable.

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Signature Date

Please keep a copy of this form for your records.