

PLEASE COMPLETE THIS FORM
IN BLOCK LETTER PRINT USE
BLACK INK

MONUMENTAL LIFE INSURANCE COMPANY
ENROLLMENT FORM
AMERICAN UNIVERSITY OF THE CARIBBEAN

PROCESSOR STAMP DATE RECEIVED HERE

[Stamp Area]

Policy CFL210F

SOCIAL SECURITY# _____ or SCHOOL ID# _____

PRIMARY INSURED
STUDENT NAME: _____

_____ Last (Family) Name
_____ First (Given) Name _____ Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ EXPECTED DATE OF GRADUATION _____

MAILING ADDRESS: _____
_____ House/Building Number and Street Name
_____ Apt. or P.O. Box # or Rural Route _____ City _____ Country _____ State _____ ZIP _____ Code

PERMANENT ADDRESS: _____
_____ House/Building Number and Street Name
_____ Apt. or P.O. Box # or Rural Route _____ City _____ Country _____ State _____ ZIP _____ Code

TELEPHONE# _____ E-MAIL ADDRESS: _____

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

SPOUSE: _____ Male Female Date of Birth: _____
Social Security Number (Check One) Month Day Year

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

CHILD: _____ Male Female Date of Birth: _____
Social Security Number (Check One) Month Day Year

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

CHILD: _____ Male Female Date of Birth: _____
Social Security Number (Check One) Month Day Year

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

CHILD: _____ Male Female Date of Birth: _____
Social Security Number (Check One) Month Day Year

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

CHILD: _____ Male Female Date of Birth: _____
Social Security Number (Check One) Month Day Year

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

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the Company or a representative of 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 form: 2) Rates are not pro-rated other than as listed on this enrollment form: 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.

STUDENTS SIGNATURE: _____ DATE: _____

CAMPUS LOCATION

American University of the Caribbean

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: ALL

Periods:

Spring

Summer

SPOUSE

E. Under Age 30

\$ 700.00

\$ 700.00

F. Age 30 and Older

\$ 905.00

\$ 905.00

CHILDREN

G. Children

\$ 270.00

\$ 270.00

The above rates include an administrative fee.

Periods:

Spring

01/05/10 - 05/04/10

Summer

05/05/10 - 09/01/10

RETURN ENROLLMENT FORM TO:

American University of the Caribbean
Medical Education Administrative Services
901 Ponce de Leon Blvd., Suite 700
Coral Gables, FL 33134-3036
Attention: Silvia
healthinsurance@aucmed.edu