

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 CFL210H

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 for my dependents under the University's student insurance plan.  
Below are the choices I have made.

**PLEASE CHECK ALL APPROPRIATE BOXES**  
**INSURED CATEGORY: ALL**

Periods:	Fall	Spring	Summer
<b><u>SPOUSE</u></b>			
E. Under Age 30	<input type="checkbox"/> \$ 700.00	<input type="checkbox"/> \$ 700.00	<input type="checkbox"/> \$ 700.00
F. Age 30 and Older	<input type="checkbox"/> \$ 905.00	<input type="checkbox"/> \$ 905.00	<input type="checkbox"/> \$ 905.00
<b><u>CHILDREN</u></b>			
G. Children	<input type="checkbox"/> \$ 270.00	<input type="checkbox"/> \$ 270.00	<input type="checkbox"/> \$ 270.00

The above rates include an administrative fee.

Periods:  
 Fall 2011       08/29/11 to 01/01/12  
 Spring 2012     01/02/12 to 05/06/12  
 Summer 2012    05/07/12 to 09/02/12

**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