

**2010-2011
SAN DIEGO CHRISTIAN COLLEGE
INSURANCE ENROLLMENT/WAIVER FORM**

1. COMPLETE THE FORM BELOW. PLEASE PRINT CLEARLY.

STUDENT'S LAST NAME		STUDENT'S FIRST NAME			M.I.
STUDENT'S PERMANENT U.S. MAILING ADDRESS (NUMBER AND STREET NAME)	APT/BOX #	CITY	STATE	ZIP	
STUDENT'S PHONE NUMBER		STUDENT'S E-MAIL ADDRESS			
STUDENT'S SOCIAL SECURITY NO.	STUDENT ID NUMBER	STUDENT'S DATE OF BIRTH (MM/DD/YY)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

2. IF YOU WISH TO ENROLL IN THE SDCC STUDENT INSURANCE PLAN, PLEASE CHECK THE APPROPRIATE TERM(S). (SKIP TO #4 IF YOU ARE WAIVING COVERAGE.)

<i>Enrollment Deadline</i>	Fall	Spring/Summer
	08/01/10 To 01/10/11 08/01/10	01/10/11 To 08/01/11 01/10/11
Student	<input type="checkbox"/> \$ 339.00	<input type="checkbox"/> \$ 468.00
Spouse	<input type="checkbox"/> \$ 785.00	<input type="checkbox"/> \$ 1,086.00
Each Child	<input type="checkbox"/> \$ 667.00	<input type="checkbox"/> \$ 921.00

PLEASE NOTE: Dental and vision benefits are not provided by the student insurance plan. If you wish to enroll in a voluntary dental/vision discount plan, please contact Renaissance Insurance Agency, Inc. at 1-800-537-1777 or visit www.renstudent.com/smilesaver.

3. LIST DEPENDENTS TO BE INSURED BELOW, IF APPLICABLE. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO INSURED UNDER THIS PLAN.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER	SEX
SPOUSE _____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD _____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD _____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD _____	_____	_____	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

By signing below, I verify that the information above is true and accurate.

STUDENT'S SIGNATURE _____ DATE SIGNED _____

4. IF YOU WISH TO WAIVE ENROLLMENT IN THE SDCC INSURANCE PLAN, COMPLETE THE INFORMATION BELOW.

A) Indicate the term for which you are waiving coverage:

Term	Waiver Deadline
<input type="checkbox"/> Fall (08/01/10 To 01/10/11)	08/01/10
<input type="checkbox"/> Spring/Summer (01/10/11 To 08/01/11)	01/10/11

B) Provide information on your current insurance plan:

Name of Policyholder (Student/Spouse/Parent) _____

Name of Insurance Company _____

Expiration Date _____ Policy Number _____

C) Sign and date.

By signing below, I confirm that I will not be joining the College-sponsored health insurance plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at San Diego Christian College, and that the College will not be responsible for any of my medical expense. I am covered under the policy indicated above.

STUDENT'S SIGNATURE _____ DATE SIGNED _____

5. RETURN THIS FORM AND A COPY OF YOUR INSURANCE CARD IF YOU ARE WAIVING COVERAGE UNDER THE COLLEGE PLAN BY THE DEADLINE DATE TO:

SAN DIEGO CHRISTIAN COLLEGE
BUSINESS OFFICE
2100 GREENFIELD DRIVE
EL CAJON, CA 92019