

**UNIVERSITY OF SOUTHERN NEVADA
2010-2011 STUDENT INJURY AND SICKNESS INSURANCE PLAN
DEPENDENT ENROLLMENT FORM**

TO ENROLL DEPENDENTS, COMPLETE THIS FORM. PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS.

1. PLEASE FILL IN STUDENT INFORMATION BELOW.

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. PLEASE SELECT THE STUDENT'S PROGRAM, THEN CHECK DEPENDENT ENROLLEE TYPE.

Program	Effective Date	Termination Date	Enrollment Deadline	Enrollee	Cost of Coverage
<input type="checkbox"/> PHARMACY P1 (2013), P2 (2012), P3 (2011)	08/25/10	08/25/11	09/25/10	<input type="checkbox"/> SPOUSE \$ 2,161.00 <input type="checkbox"/> EACH CHILD \$ 1,418.00	
<input type="checkbox"/> PHARMACY P3 (2010)	08/27/10	09/27/10	08/27/10	<input type="checkbox"/> SPOUSE \$ 180.00 <input type="checkbox"/> EACH CHILD \$ 118.00	
<input type="checkbox"/> PHARMACY-MBA P1-MBA (2013)	07/06/10	08/25/11	08/06/10	<input type="checkbox"/> SPOUSE \$ 2,521.00 <input type="checkbox"/> EACH CHILD \$ 1,654.00	
<input type="checkbox"/> PHARMACY-MBA P2-MBA (2012), P3-MBA (2011)	08/25/10	08/25/11	09/25/10	<input type="checkbox"/> SPOUSE \$ 2,161.00 <input type="checkbox"/> EACH CHILD \$ 1,418.00	
<input type="checkbox"/> PHARMACY-MBA P3-MBA (2010)	08/27/10	11/27/10	09/27/10	<input type="checkbox"/> SPOUSE \$ 540.00 <input type="checkbox"/> EACH CHILD \$ 355.00	
<input type="checkbox"/> MBA	07/06/10	07/05/11	08/06/10	<input type="checkbox"/> SPOUSE \$ 2,161.00 <input type="checkbox"/> EACH CHILD \$ 1,418.00	
<input type="checkbox"/> DENTAL	07/06/10	07/05/11	08/06/10	<input type="checkbox"/> SPOUSE \$ 2,161.00 <input type="checkbox"/> EACH CHILD \$ 1,418.00	
<input type="checkbox"/> NURSING	08/09/10	08/08/11	09/09/10	<input type="checkbox"/> SPOUSE \$ 2,161.00 <input type="checkbox"/> EACH CHILD \$ 1,418.00	
<input type="checkbox"/> NURSING - WINTER START	01/20/11	08/08/11	02/20/11	<input type="checkbox"/> SPOUSE \$ 1,261.00 <input type="checkbox"/> EACH CHILD \$ 827.00	
<input type="checkbox"/> NURSING - ABSN 2	10/05/10	08/08/11	11/05/10	<input type="checkbox"/> SPOUSE \$ 1,801.00 <input type="checkbox"/> EACH CHILD \$ 1,182.00	
<input type="checkbox"/> NURSING - ABSN 3	02/07/11	08/08/11	03/07/11	<input type="checkbox"/> SPOUSE \$ 1,081.00 <input type="checkbox"/> EACH CHILD \$ 709.00	
<input type="checkbox"/> NURSING - ABSN 4	04/05/11	08/08/11	05/05/11	<input type="checkbox"/> SPOUSE \$ 721.00 <input type="checkbox"/> EACH CHILD \$ 473.00	

3. WRITE IN THE APPROPRIATE COST OF COVERAGE (AS INDICATED ABOVE) FOR EACH PERSON ENROLLING:

<input type="checkbox"/> EACH CHILD	\$	_____
NUMBER OF CHILDREN	X	_____
TOTAL PREMIUM FOR CHILD(REN)	=	_____
<input type="checkbox"/> SPOUSE	+	_____
TOTAL PREMIUM	=	_____
TOTAL PAYMENT	\$	_____

PLEASE COMPLETE THE SECOND PAGE OF THIS FORM.

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4. LIST DEPENDENTS TO BE INSURED:

	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
CHILD	_____	_____	___	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F

5. MAKE CHECK OR MONEY ORDER PAYABLE TO "RENAISSANCE INSURANCE AGENCY, INC." OR COMPLETE CREDIT CARD PAYMENT SECTION BELOW.

<p>CREDIT CARD AUTHORIZATION — CREDIT CARD PAYMENTS CANNOT BE ACCEPTED OVER THE PHONE OR BY FAX WILL APPEAR AS "STUDENT HEALTH INSURANCE, RENAISSANCE AGENCIES" ON YOUR CREDIT CARD BILL</p> <p>MasterCard # or Visa # _____ Expiration Date _____ Charge Amount _____</p> <p>Name of Cardholder _____</p> <p>Signature of Cardholder _____</p>
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6. RETURN WITH THIS FORM AND PAYMENT TO:

RENAISSANCE INSURANCE AGENCY, INC.
P.O. BOX 2300
SANTA MONICA, CA 90407-2300

ENROLLMENT FORM MUST BE POSTMARKED BY THE DEADLINE DATE.

7. SIGN BELOW:

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND, AND AGREE TO THE TERMS AND CONDITIONS OF COVERAGE AS OUTLINED IN THE BROCHURE.

STUDENT'S SIGNATURE X _____ DATE _____