GUARANTEE TRUST LIFE INSURANCE COMPANY

Student Accident & Sickness Insurance Program

Designed for the Students of

EMMANUEL COLLEGE

2001-2002

Policy Number: 204-145-003-P

STUDENT ACCIDENT AND SICKNESS INSURANCE PROGRAM

The following pages are a brief description of the Accident and Sickness Insurance Program. This plan is underwritten by Guarantee Trust Life Insurance Company. The exact provisions governing this insurance are contained in the Policy issued to the school and may be viewed at the Health and Counseling Office during business hours. The Policy shall control in the event of any conflict between this Brochure and the Policy. **Please retain this Brochure for future reference.**

PREFERRED PROVIDER INFORMATION

The Consolidated Health Plans Preferred Provider Network is available to you in Massachusetts when you enroll in this plan. It provides quality health care at discounted rates.

THE PLAN DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER. However, if you do, you will reduce your out-of-pocket health care expenses.

A complete listing of the Consolidated Health Plans Preferred Provider Network including Beth Israel Deaconess Medical Center, is available on campus at the Health and Counseling Office and the Simmons College Health Center.

Additional information may be obtained by contacting Consolidated Health Plans at (800) 633-7867, or by viewing their website at www.consolidatedhealthplan.com. "Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. The availability of specific providers is subject to change without notice. You should always confirm that a Preferred Provider is participating at the time services are required by calling Consolidated Health Plans at (800) 633-7867 or by asking the provider when you make an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out of Network" providers have not agreed to any prearranged fee schedules. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

Regardless of the provider you are responsible for the payment of your Deductible. You must satisfy your deductible before benefits are paid. We will pay accordingly.

ELIGIBILITY

All registered undergraduate and graduate students taking 3/4 or full-time credit are required to purchase this insurance plan unless proof of comparable coverage is furnished. All other registered students taking more than 3 but less than 9 credit hours are eligible to enroll in this insurance plan.
Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased, unless unable to attend due to medical reasons and placed on a medical leave of absence. Home study, correspondence, and television (tv) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Policy Eligibility requirements have been met. If and whenever the Company discovers that the Policy Eligibility requirements have not been met, its only obligation is refund of premium.
Eligible students who enroll may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age who are not self-supporting. Dependent Eligibility expires concurrently with that of the Insured student.

POLICY TERM

The Master Policy which is on file at the college, becomes effective at 12:01 a.m., August 15, 2001. For students not enrolling through the school's waiver program, coverage becomes effective on that date, or the date premium is received by the Company, or its authorized representative, whichever is later. The Master Policy terminates at 12:01 a.m., August 15, 2002. Coverage for students who enroll in the Plan for the Spring Semester, is effective at 12:01 a.m. on January 1, 2002 and terminates at 12:01 a.m. on August 15, 2002. Coverage for students who enroll in the Plan for the Summer Semester, is effective at 12:01 a.m. on May 10, 2002 and terminates at 12:01 a.m. on August 15, 2002.

REFUND OF PREMIUM

Except for medical withdrawal due to a covered Injury or Sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policy and a full refund of the premium will be made. Students withdrawing after such 31 days will remain covered under the Policy for the full period for which premium has been paid and no refund will be allowed.

Covered Persons entering the Armed Forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person upon written request received by the Company within 90 days of withdrawal from school. Refunds for any other reason are not available.

TERMINATION OF COVERAGE

A Covered Person's coverage will terminate on the earliest of one of the following; upon entry into the armed forces of any country or; the end of the coverage period for which premium was paid or; the date the Policy terminates.
No benefits are payable after termination, except as stated in the Extension of Benefits provision.

COVERAGE FOR DEPENDENTS

If You are covered under the Policy, coverage may be purchased for Your eligible Dependents. Your Dependents will be covered for the same benefits for which You are covered. Dependent coverage, if any, begins and ends with Your coverage.
A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the 31st day following birth. During the 31-day period, we must receive written notice of the birth and the required premium must be paid.

EXTENSION OF BENEFITS AFTER TERMINATION

The coverage provided under the Policy ceases on the Termination Date. However, if a Covered Person is hospital confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits After Termination provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

CONTINUATION PRIVILEGE

Covered Persons who become ineligible for coverage due to leaving the school due to graduation, or for other purposes, may continue coverage from the termination date by calling University Health Plans at (617) 723-2120 or (800) 437-6448 prior to 8/15/02.

DEFINITIONS

Accident means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while a Covered Person is insured under the policy.

Covered Medical Expense means the Reasonable and Customary Charge for a service or supply, which is performed or given under the direction of a Doctor for the Medically Necessary treatment of Injury or Sickness pursuant to the terms of the Policy

Covered Person means You or a Dependent insured under the Plan.

Deductible means the amount of Reasonable and Customary Charges which must be paid by a Covered Person before benefits are payable under the Policy. It applies separately to each Covered Person.

"Dependent" means a person who resides with You and is Your:

- legal spouse;
- unmarried child(ren) under age 19 who are/is financially dependent on You. The term child includes a stepchild, a foster child, an adopted child and a child legally placed with You who is a prospective adoptive parent, even if the adoption has not been finalized.
- child, despite attaining age 19, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and dependent on You for financial support

Doctor means a licensed practitioner of the healing arts acting within the scope of his or her license. The Doctor may not be a member of the Covered Person's immediate family. Doctor includes Doctor assistants, certified nurse practitioners, certified psychiatric mental health clinical nurse specialists, and certified nurse-midwives.

Home Health Care means:

- part-time nursing care, by or supervised by, a registered graduate nurse; part-time home health aide service which consists mainly of caring for the patient; physical, occupational, respiratory or speech therapy; nutrition counseling; medical social services by a qualified social worker licensed by the jurisdiction where services are rendered; medical supplies, prosthetic and orthopedic appliances, rental or purchase of durable medical equipment, drugs and medicines obtainable by prescription only, including insulin, but only to the extent that such charges would have considered covered expenses had the Covered Person required confinement in a hospital or in a skilled nursing facility.

Hospice Care means:

- Doctor services;
- Nursing care provided by or under the supervision of a registered professional nurse;
- Social services;
- Volunteer services; and
- Counseling services provided by a professional or volunteer staff under professional supervision.

Injury means bodily harm caused by an Accident, which results in loss. All Injuries sustained in one Accident, including related conditions, will be considered one Injury.

Loss means medical expense caused by Injury and Sickness and covered by the Policy.

Medically Necessary means medical and dental services, treatments or supplies which are: (1) recommended by a Doctor; (2) consistent with generally accepted medical practice for Injury or Sickness, as determined by Us; (3) considered appropriate by Doctors in the USA; (4) accepted as safe and reliable by a recognized medical specialty or board. The fact that a Doctor may prescribe, order or recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Reasonable and Customary Charge (R&C) means the normal and customary charge of the provider, incurred by the Covered Person, in the absence of insurance for a service or supply, but not more than the prevailing charge in the area.

Sickness (Sick) means illness or disease which begins or for which expense is incurred while coverage is in force under the Policy. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of a Sickness will be considered one Sickness.

"We", "Our", or "Us" means Guarantee Trust Life Insurance Company.

"You", "Your" or "Yours" means the insured student.

BASIC ACCIDENT AND SICKNESS EXPENSE BENEFITS

The Policy will pay **80%** of Covered Medical Expenses incurred by a Covered Person due to a covered Sickness or covered Injury, up to a maximum benefit of $50,000 per Sickness or Injury. Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Medical Expenses are:

Intensive Care/Hospital Expense: Hospital room and board and general nursing care while hospital confined. The Policy will pay 100% if a preferred provider is utilized.

Miscellaneous Hospital Expense: Miscellaneous hospital charges incurred while hospital confined, including expenses for: anesthesia; operating room; laboratory tests; x-rays; oxygen tent; pre-admission tests; medicines or supplies; dressings; other non-room and board expenses; prescription drugs (excluding take-home drugs). The Policy will pay 100% if a preferred provider is utilized.

In-Hospital Doctor's Expense: Services of a Doctor during hospital confinement, limited to one visit per day. This benefit does not apply when related to surgery.

Ambulance Expense: Use of an ambulance to or from the hospital, up to a $250 maximum.

Surgical Expense: Doctor's fee for surgery, up to a $5,000 maximum based in accordance with data provided by Ingenix. No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.

Anesthesia Expense: Services of an anesthetist who is not employed or retained by the hospital in which the surgery is performed, up to 30% of the amount paid the surgeon.

Assistant Surgeon's Expense: Service of an assistant surgeon required by the hospital, up to 30% of the amount paid the surgeon.

Outpatient Miscellaneous Expense: Outpatient services are subject to a maximum benefit of $1,500 for each Sickness or Injury, including expenses for:

- Doctor's visits, limited to 1 visit per day;

- Physiotherapy, limited to 1 visit per day;
- Day surgery miscellaneous, including operating room, laboratory tests, x-rays; anesthesia, drugs or medicines and supplies. Day surgery miscellaneous expense is based on the Outpatient Surgical Facility Charge Index.
- Laboratory tests and x-ray examinations; and
- Chemotherapy and radiation therapy.
- Office visits at Simmons Health Center or Beth Israel Deaconess Medical Center will be paid at 100%.

Outpatient Treatment subject to the following per visit Deductible: Emergency room - $50, which is waived when admitted to a preferred provider hospital.

Braces and Appliances Expense: up to $100, paid under Outpatient Miscellaneous Expense. A written prescription must accompany the claim when submitted. Replacement braces and appliances not covered.

CAT Scan/MRI Expense: Up to a $2,000 maximum benefit.

Sickness Dental Expense: Services of a Doctor for the removal of impacted wisdom teeth, up to $50 per tooth. No other benefits for impacted wisdom teeth will be paid.

Consultant Physician Expense: Up to a maximum benefit of $250 when requested and approved by the attending Doctor.

Accidental Dental Expense: Up to $500 per tooth for Injury to a sound, natural tooth.

Allergy Testing/Treatment Expense: Up to $225 per policy year.

Mental or Nervous Disorders Expense:

Inpatient: For treatment in a mental hospital under the direction and supervision of the department of mental health, or in a private mental hospital licensed by the department of mental health, up to 60 days per calendar year. The period of confinement may be calculated by substituting 2 days of outpatient treatment at a community mental health center or other mental health clinic or psychiatric day treatment center licensed by the department of public health or 2 days of outpatient day treatment at a psychiatric hospital licensed by the department of mental health, for 1 day of inpatient hospital care.

Outpatient: Up to a maximum of $1,500 over a 12-month period. Outpatient services must be furnished by a licensed or accredited health service organization or hospital, or by a fully licensed psychotherapist or psychologist or licensed independent clinical social worker.

All Covered Medical Expenses incurred as a result of Mental or Nervous Disorders are subject to the above stated maximums; if otherwise provided under the Policy, this includes items such as Prescriptions and diagnostic testing.

Substance Abuse Expense:

Inpatient: Confinement in an accredited or licensed hospital or in any other public or private facility providing services especially for the detoxification or rehabilitation and which is licensed by the department of public health, or in a residential alcohol treatment program, up to 30 days in any calendar year.

Outpatient: Up to a maximum of $500 over a 12-month period. Outpatient services must be furnished by an accredited or licensed hospital or by any public or private facility or portion thereof providing services especially for the rehabilitation of intoxicated persons or alcoholics.

All Covered Medical Expenses incurred as a result of Alcoholism are subject to the above stated maximums; if otherwise provided under the Policy, this includes items such as Prescription Drugs and diagnostic testing.

Additional Benefits: Coverage is also mandated by the Massachusetts State Board of Insurance for: biologically based mental illness; diagnosis and treatment of non-biologically-based mental, behavioral or emotional disorders for children and adolescents under the age of 19; cardiac rehabilitation; cytologic screenings; mammograms; nonprescription enteral formulas; equipment and supplies for treatment of diabetes; diagnosis and treatment of infertility; bone marrow transplants for treatment of breast cancer; scalp hair prosthesis; home health care; hospice care; well-child care; and early intervention services. A detail of these benefits may be found in the Policy on file at the College.

MATERNITY BENEFIT

Benefits will be paid for normal pregnancy and normal childbirth as any other Sickness. Covered Medical Expenses include: 1) Doctor's visits; 2) diagnostic services; 3) obstetrical/surgical procedures; 4) hospital room and board; 5) hospital miscellaneous expenses; and 6) routine newborn infant care while hospital confined not to exceed a maximum of 48 hours - for vaginal delivery or 96 hours - for cesarean section.

Coverage is provided for services provided by and facilities used by licensed certified nurse midwives. Benefits will cover prenatal care, childbirth and post-partum care to the same extent as medical conditions not related to pregnancy.

COORDINATION OF BENEFITS

Benefits provided by the Policy are intended to augment any existing health insurance which may apply to a Covered Person. Benefits are subject to coordination with any other group,

The time for which You are covered under this plan may be eligible for crediting toward satisfaction in a plan under which You subsequently become covered. When Your coverage terminates under this Plan, Consolidated Health Plans will, at Your request, issue a Certificate of Coverage to You for that purpose.

EXCLUSIONS

The policy does not cover Loss nor provide benefits for:

1. Expenses for daily hospital room and board higher than the usual semi-private room charge or higher than the usual charge for the Intensive Care Unit, if applicable.
2. Expenses incurred for medical services, treatments and supplies for which no charge would have been normally made in the absence of insurance.
3. Services normally provided without charge by your Health Services, Infirmary or Hospital or any employees thereof.

4. Surgery for the correction of refractive error and services in connection with eye examinations, eye glasses or contact lenses or hearing aids, except as required for a repair due to an Accident in which the Covered Person sustains an Injury.
5. Loss resulting from participation in an illegal occupation, riot, civil commotion or act of terrorism; or committing, or attempting to commit, a felony.
6. Elective plastic or cosmetic surgery, unless resulting directly from an Injury which necessitated medical treatment within 24 hours of the Accident. This exclusion does not apply to cosmetic surgery made necessary by an Injury or a congenital disease or deformity of a newborn child who is a Dependent insured under the Policy.
7. Loss resulting from air travel, except as a fare-paying passenger on a commercial airline.
8. Injury or Sickness resulting from war, declared or undeclared.
9. Injury sustained or Sickness contracted while in the armed forces of any country.
10. An occupational loss covered by any occupational benefit plan, Workers' Compensation Act or similar law except when mandated by law.
11. Treatment, services or supplies received in a Government hospital unless the Covered Person is legally obligated to pay such charges in the absence of insurance.
12. Outpatient Expense incurred for treatment of drug, alcohol, mental or nervous disorders except as mandated.
13. Routine Newborn Infant care, well-baby nursery and related Physician charges in excess of forty-eight hours of inpatient care following a vaginal delivery and in excess of ninety-six hours of inpatient care following a cesarean section delivery;
14. Expense incurred for treatment of injuries resulting from any motor vehicle accident to the extent covered by other valid and collectible insurance, or third party action.
15. Expenses, which are reimbursable by any other valid and collectible hospital or insurance plan, but such charges in excess thereof shall be covered as otherwise provided.
16. Services and supplies not Medically Necessary for the diagnosis or treatment of a Sickness or an Injury.
17. Treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extractions of teeth, TMJ dysfunction or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia. This exclusion does not apply to the repairs to sound natural teeth caused by an injury. This exclusion does not apply to the removal of impacted wisdom teeth.
18. Injury resulting from participation in interscholastic, intercollegiate, or professional sports, including practices and conditioning, play or travel or arising from scuba diving, hang gliding, parachuting or bungee jumping.

ITEMS NOT COVERED

Unless specified elsewhere, or deemed to be medically necessary, Items Not Covered includes but are not limited to: surgery and/or treatment for acne; acupuncture; alopecia; biofeedback-type services; birth control; breast implants; breast reduction; circumcision; corns; calluses; bunions; cosmetic procedures, except cosmetic surgery required to correct any Injury for which benefits are otherwise payable under the Policy; family planning; fertility tests; gynecomastia; hirsutism; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided under the "Benefits for Infertility"; learning disabilities; nasal and sinus surgery; nicotine addiction; nonmalignant warts, moles and lesions; obesity and any condition resulting therefrom (including hernia of any kind); patient controlled analgesia (PCA); premarital examinations; preventive medicines or vaccines except when required for the treatment of a covered Injury; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders, including testing thereof; temporomandibular joint dysfunction; tubal ligation; vasectomy; and weight reduction. Elective Surgery and Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or, 2) are not recognized and generally accepted medical practice in the United States.

MEDICAL EVACUATION BENEFIT
$10,000 Maximum Benefit

When hospital confined for at least five (5) consecutive days, and recommended and approved by the attending Doctor, benefits will be paid up to $10,000 for Your evacuation to Your home country. This benefit is limited to the Maximum Benefits specified above.

REPATRIATION BENEFIT
$7,500 Maximum Benefit

If You die while insured under the Policy, benefits will be paid up to $7,500 for preparing and transporting Your remains to Your home country. This benefit is limited to the Maximum Benefit specified above. No additional benefits will be paid under Basic or Major Medical coverage for Repatriation.

Any provision of the Policy or this brochure which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the mandates of the state.

CLAIM PROCEDURE

In the event of Covered Accident or Sickness:

1. Obtain claim forms from the Health and Counseling Office, or by contacting Consolidated Health Plans at (800) 633-7867, or by accessing their website at www.consolidatedhealthplan.com.
2. You must submit a claim form for each separate injury or sickness. The claim form should be submitted within 30 days after the date of accident or commencement of a covered illness, or as soon as reasonably possible.
3. Itemized billings (Written Proof of Loss) should be submitted by your health care provider or the Covered Person within 90 days of treatment, or as soon as reasonably possible. *(*NOTE*: Bills submitted after one year will not be considered for payment in absence of legal capacity.)*

All Claim forms should be submitted to:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
195 Stafford Street
Springfield, MA 01104-3503
Toll Free (800) 633-7867
www.consolidatedhealthplan.com
For Questions Regarding Insurance Benefits, Claims Processing, and Identification Cards please contact Consolidated Health Plans.

Servicing Broker:
UNIVERSITY HEALTH PLANS, INC.
15 Broad Street
Boston, MA 02109
Local: (617) 723-2120
Out of Area: (800) 437-6448
www.universityhealthplans.com
email: info@univhealthplans.com

The Plan is underwritten and offered by:
GUARANTEE TRUST LIFE INSURANCE COMPANY
Policy Number: 204-145-003-P

IMPORTANT NOTICE
This information provides a brief description of the important features of this Insurance program. It is not a contract. Terms and conditions of the coverage are set forth in policy number. Please keep this material with your important papers.

VISION BENEFITS

The Vision One discount program is available to participants in the Student Health Insurance Plan through Cole Vision® at no additional cost. This program may help you save on many eye care products, including eyeglasses and contact lenses, nonprescription sunglasses, contact lens solutions and accessories.

The Vision One program is available at many optical centers nationwide – such as **Sears, JCPenney, Target,** most **Pearle Vision** Centers and others – as well as through selected independent optometrist and ophthalmologist offices.
When you visit a Vision One location, show your Student Health Insurance card, and any applicable services or merchandise you receive will be discounted right at the point of purchase. There are no claim forms to complete and no waiting for reimbursement.
Here is an example of some of the discounts you are eligible for:

Frames	**Vision One Cost**	**Typical Savings**
Up to $60 retail	$25	58%
$60 to $80 retail	$35	56%
$80 to $100 retail	$45	55%
Over $100 retail		35% off retail
Exams - Spectacle		$5 discount
Lenses		
Single Vision	$30	46%
Bifocal	$50	42%
Trifocal	$60	45%
Lens Options	**Additional**	
Standard Progressive (no-line bifocal)	$50	33%
Polycarbonate	$30	40%
Scratch Resistant Coating	$12	40%
Ultraviolet Coating	$12	40%
Anti-Reflective Coating	$35	30%
Photochromic	$30	25%
Solid or Gradient Tint	$ 8	33%
Contact Lenses		
Non-Disposable Contacts		20%
Disposable Contacts		10%
Exams – **Contacts**		$10 discount

To find the nearest Vision One location log on to the Cole Managed Vision website at www.cmvc.com or call 1-800-424-1155, weekdays from 9 a.m. to 9 p.m. ET and Saturdays from 9 a.m. to 5 p.m. ET to speak to a representative. Cole Managed Vision Plan #47034.

EMMANUEL COLLEGE **GUARANTEE TRUST INSURANCE COMPANY**

STUDENT INSURANCE ENROLLMENT CARD – FOR UNDERGRADUATE STUDENTS & DEPENDENTS

(PLEASE PRINT)

Students Name_____
Last First MI

Permanent U.S. Address_____
Street or PO Box City State Zip

Social Security #_____Date of Birth_____Phone#_____ ❒Male ❒Female

List Dependents to be insured below. Dependent coverage is available ONLY if the student is also insured under the Plan.

	Last Name	First Name	MI	Date of Birth	Social Security #
Spouse:					
Child:					
Child:					
Child:					

Payment Instructions: Make check or money order payable to Emmanuel College in U.S. dollars. Mail this enrollment card along with premium payment to Emmanuel College, Business Office, 400 The Fenway, Boston, MA 02115.

PLEASE COMPLETE BOTH SIDES

Please check all appropriate boxes:

	Annual 8/15/01 – 8/15/02	Spring 1/1/02 – 8/15/02	Summer 5/10/02 – 8/15/02
Student	❒ $495.00	❒ $332.00	❒ $129.00
Spouse	❒$2,220.00	❒$1,487.00	❒ $577.00
Each Child	❒$1,066.00	❒ $714.00	❒ $277.00

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. It is the students responsibility for timely renewal payments. By signing below, the student acknowledges the following: 1) He/She has carefully read the Brochure and elects to enroll as indicted on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the Eligibility requirements for this coverage as described in the Brochure; 4) If it is later determined that the student is not eligible, the premium will be refunded by the insurance company; and 5) Other than Eligibility, the premium is not refundable.

Signature of Student_____

EMMANUEL COLLEGE **GUARANTEE TRUST INSURANCE COMPANY**

STUDENT INSURANCE ENROLLMENT CARD – FOR GRADUATE STUDENTS & DEPENDENTS

(PLEASE PRINT)

Students Name_____
Last First MI

Permanent U.S. Address_____
Street or PO Box City State Zip

Social Security #_____Date of Birth_____Phone#_____ ❒Male ❒Female

List Dependents to be insured below. Dependent coverage is available ONLY if the student is also insured under the Plan.

	Last Name	First Name	MI	Date of Birth	Social Security #
Spouse:					
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Payment Instructions: Make check or money order payable to Emmanuel College in U.S. dollars. Mail this enrollment card along with premium payment to Emmanuel College, Business Office, 400 The Fenway, Boston, MA 02115.

PLEASE COMPLETE BOTH SIDES

Please check all appropriate boxes:

	Annual 8/15/01 – 8/15/02	Spring 1/1/02 – 8/15/02	Summer 5/10/02 – 8/15/02
Student	❒ $745.00	❒ $500.00	❒ $194.00
Spouse	❒$2,220.00	❒$1,487.00	❒ $577.00
Each Child	❒$1,066.00	❒ $714.00	❒ $277.00

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. It is the students responsibility for timely renewal payments. By signing below, the student acknowledges the following: 1) He/She has carefully read the Brochure and elects to enroll as indicted on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the Eligibility requirements for this coverage as described in the Brochure; 4) If it is later determined that the student is not eligible, the premium will be refunded by the insurance company; and 5) Other than Eligibility, the premium is not refundable.

Signature of Student_____Date_____

Colleges of the Fenway
EMMANUEL COLLEGE
STUDENT HEALTH INSURANCE WAIVER
2001-2002

Please complete and return to: Business Office/Student Accounts

_____ _____
Student Name Social Security Number

❒ I will not be joining the EMMANUEL COLLEGE sponsored health insurance plan. I fully understand that I am legally responsible for any medical expensive incurred during my enrollment at EMMANUEL COLLEGE and that EMMANUEL COLLEGE will not be responsible for any medical expense.

I AM COVERED UNDER THE FOLLOWING POLICY:

Insurance Company Name_____ Policy#_____

Subscriber_____ Relationship to Student_____

_____ _____ _____
Student's Signature