

**Suffolk University**  
**English Language Institute for International Students**  
**Student Accident and Sickness Insurance Plan**  
**Summer 2009 Enrollment Form**

(PLEASE PRINT)

Name \_\_\_\_\_  
Last First MI

U.S. Mailing Address \_\_\_\_\_  
Street or PO Box City State Zip

Date of Birth \_\_\_\_\_ Gender: \_\_\_\_\_ Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Category	Premium	Period of Coverage
Summer Session I	<input type="checkbox"/> \$159	5/18/09 – 6/26/09
Summer Session II	<input type="checkbox"/> \$159	7/7/09 – 8/14/09

The **deadline to enroll** for Summer Session I is **5/21/09** and Summer Session II is **7/10/09**.

**PAYMENT INSTRUCTIONS:**

Please mail completed form and premium to: University Health Plans, One Batterymarch Park, Quincy, MA 02169.  
*Please note Credit Card payments are not accepted. Payment should be made in form of a Personal Check, US Bank Check or US Money Order payable to University Health Plans.*

**DECLARATION OF INTERNATIONAL STUDENTS EARLY ARRIVAL:**

I have carefully read the brochure at [www.universityhealthplans.com/brochures\\_pdf/Suffolk0809.pdf](http://www.universityhealthplans.com/brochures_pdf/Suffolk0809.pdf) and elect to enroll as indicated. Rates are not pro-rated other than as listed. I permit the University to provide University Health Plans with my enrollment status for purposes of eligibility under this Plan. I warrant that the information I have provided on this application form is true and I am aware that if I provide false information, my coverage can be made void. I understand that if it is later determined that I'm not eligible for coverage, the premium will be refunded, but the premium is not refundable for reasons other than eligibility.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

*Please contact University Health Plans at [info@univhealthplans.com](mailto:info@univhealthplans.com) or (800) 437-6448 if you have any questions about enrolling yourself in the plan.*