

The MEGA Life & Health Insurance Company
CAL POLY SAN LUIS OBISPO - DOMESTIC STUDENT HEALTH INSURANCE
2004-2005 ENROLLMENT FORM
You may also purchase the insurance plan online at www.csuhealthlink.com.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

	ANNUAL 9/13/04-9/12/05	FALL 9/13/04-1/3/05	WINTER 1/3/05-3/28/05	SPRING/SUMMER 3/28/05-9/12/05	SUMMER 6/20/05-9/12/05
Enrollment Deadlines	11/1/04	11/1/04	3/1/05	5/15/05	8/1/05
Student, Age 24 & Under*	<input type="checkbox"/> \$ 935	<input type="checkbox"/> \$ 321	<input type="checkbox"/> \$ 243	<input type="checkbox"/> \$ 399	<input type="checkbox"/> \$ 243
Student, Age 25-30*	<input type="checkbox"/> \$1,330	<input type="checkbox"/> \$ 455	<input type="checkbox"/> \$ 343	<input type="checkbox"/> \$ 567	<input type="checkbox"/> \$ 343
Student, Age 31-40*	<input type="checkbox"/> \$1,823	<input type="checkbox"/> \$ 623	<input type="checkbox"/> \$ 469	<input type="checkbox"/> \$ 777	<input type="checkbox"/> \$ 469
Student, Age 41-49*	<input type="checkbox"/> \$2,069	<input type="checkbox"/> \$ 706	<input type="checkbox"/> \$ 532	<input type="checkbox"/> \$ 881	<input type="checkbox"/> \$ 532
Student, Age 50 & Over*	<input type="checkbox"/> \$3,010	<input type="checkbox"/> \$1,026	<input type="checkbox"/> \$ 772	<input type="checkbox"/> \$1,281	<input type="checkbox"/> \$ 772
<i>Dependent coverage is in addition to student coverage.</i>					
Spouse	<input type="checkbox"/> \$2,445	<input type="checkbox"/> \$ 831	<input type="checkbox"/> \$ 624	<input type="checkbox"/> \$1,039	<input type="checkbox"/> \$ 624
Per Child	<input type="checkbox"/> \$1,467	<input type="checkbox"/> \$ 482	<input type="checkbox"/> \$ 379	<input type="checkbox"/> \$ 624	<input type="checkbox"/> \$ 379
*Premium includes services: online and nurse advice.					
DELTA DENTAL					
Student Only Age 50 & Under	<input type="checkbox"/> \$ 188.16	<input type="checkbox"/> \$ 78.40	<input type="checkbox"/> \$ 78.40	<input type="checkbox"/> \$ 94.08	<input type="checkbox"/> \$ 78.40
Dental coverage is optional, not available for dependents , and may only be purchased when Medical coverage is also purchased.					

PAYMENT METHOD (Remit in US Funds Only):

Check/Money Order MAKE CHECKS PAYABLE TO: **SOMERTON STUDENT INSURANCE** (\$25.00 fee for insufficient funds)

Credit Card: Visa Master Card Account No. Expires:

MAIL PAYMENT AND ENROLLMENT FORM TO: **Somerton Student Insurance, PO Box 1287, Rancho Murieta, CA 95683**

This is limited term coverage only. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

YOU MUST COMPLETE BOTH SIDES OF THE ENROLLMENT FORM AND SIGN BELOW

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept as applicable to me the terms and conditions stated therein.

DATE _____

SIGNATURE OF STUDENT _____

04-CPSLO-D

NOTICE TO ALL HEALTH CARE PROVIDERS

This card is not a guarantee of coverage. For information concerning coverage, co-payment and claim instructions, please call Customer Service at 1-800-953-1801.

CLAIM INSTRUCTIONS

Claims must be submitted to the Company within 90 days after date of treatment. Please mail all medical and hospital bills, along with the patient's name & insured student's name, address, Social Security Number (if any), and name of the university under which the student is insured to:

AMERIBEN SOLUTIONS
P.O. Box 7186, Boise, ID 83707
1-800-953-1801 www.ameriben.com