

PLEASE COMPLETE THIS FORM  
IN BLOCK LETTER PRINT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY  
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

PROCESSOR STAMP DATE RECEIVED HERE



DeVRY UNIVERSITY

2004-278-1  
2004-278-2

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ or SCHOOL ID# \_\_\_\_\_

PRIMARY INSURED

STUDENT NAME: \_\_\_\_\_  
Last (Family) Name

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

GENDER:  Male  Female DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXPECTED DATE OF GRADUATION: \_\_\_\_\_ - \_\_\_\_\_  
Check one Month Day Year Month Year

MAILING ADDRESS: \_\_\_\_\_  
House/Building Number and Street Name

\_\_\_\_\_ Apt. or P.O. Box # or Rural Route \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

PERMANENT ADDRESS: \_\_\_\_\_  
House/Building Number and Street Name

\_\_\_\_\_ Apt. or P.O. Box # or Rural Route \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ - \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

**Complete information below for Dependents to be insured. Dependent coverage is available only for Students insured under the Plan.**

SPOUSE: \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number (Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

CHILD: \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number (Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

CHILD: \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number (Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

CHILD: \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number (Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

CHILD: \_\_\_\_\_ - \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Social Security Number (Check One) Month Day Year

\_\_\_\_\_ First (Given) Name \_\_\_\_\_ M/I \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

**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. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated 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; and 4) If it is later determined that the student is not eligible, the premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

STUDENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

