

PLEASE COMPLETE THIS FORM  
IN BLOCK LETTER PRINT  
USE BLACK INK

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

PROCESSOR STAMP DATE RECEIVED HERE



MISSISSIPPI STATE UNIVERSITY

2005-545-1

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

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

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

MAILING 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 Dependents of Students insured under the Plan.

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

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

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

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

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.**

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

# MISSISSIPPI STATE UNIVERSITY

2005-545-1

**CAMPUS LOCATION:** MISSISSIPPI STATE UNIVERSITY

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

**PLEASE CHECK ALL APPROPRIATE BOXES**  
**INSURED CATEGORY: All**

<u>PERIOD CODES</u>	Annual (A-)	Fall (F-)	Spring/ Summer (J-)	Summer (S-)
<b>ID CODES</b>				
A Student	<input type="checkbox"/> \$ 845.00	<input type="checkbox"/> \$ 308.00	<input type="checkbox"/> \$ 554.00	<input type="checkbox"/> \$ 194.00
B Spouse	<input type="checkbox"/> \$2432.00	<input type="checkbox"/> \$ 886.00	<input type="checkbox"/> \$1595.00	<input type="checkbox"/> \$ 559.00
C Each Child	<input type="checkbox"/> \$ 943.00	<input type="checkbox"/> \$ 344.00	<input type="checkbox"/> \$ 618.00	<input type="checkbox"/> \$ 217.00

**EFFECTIVE / EXPIRATION PERIODS:**

Annual	<input type="checkbox"/> 08-23-2005 to 08-22-2006
Fall	<input type="checkbox"/> 08-23-2005 to 12-31-2005
Spring/Summer	<input type="checkbox"/> 12-31-2005 to 08-22-2006
Summer	<input type="checkbox"/> 06-01-2006 to 08-22-2006

**Payment Instructions:** Make check or money order payable to Student Insurance in US dollars or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to Holland Insurance Agency, Inc., PO Box 328, Southaven, MS 38671. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

**CHARGE CARD AUTHORIZATION PAYMENT INFORMATION**

CHARGE FULL AMOUNT \$ _____	<input type="checkbox"/> VISA or <input type="checkbox"/> MASTERCARD # _____	Expiration Date _____ - _____ Month Year
AUTHORIZED SIGNATURE _____		DATE _____
<b>OR</b> PAID BY CHECK # _____		AMOUNT PAID \$ _____