

**SAINT XAVIER UNIVERSITY
AUTOMATIC PAYMENT AUTHORIZATION 2013-2014**

I request and authorize COMPANION LIFE INSURANCE COMPANY and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that there is no provision for cancellation unless admitted into the Armed Forces.

DRAFT DATE: _____ (Will be debited on the 11th of each month)

DRAFT AMOUNT: _____

Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED _____

ADDRESS OF BANK _____

CITY _____ STATE _____

NAME OF INSURED, APPLICANT (PRINT) _____

NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED _____

DEPOSITOR SOCIAL SECURITY NUMBER _____

DEPOSITOR DRIVER'S LICENSE NUMBER _____

DEPOSITOR STATE _____

RELATIONSHIP TO INSURED _____

SIGNATURE OF DEPOSITOR _____ DATE _____

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT
REQUIRES A COPY OF A VOIDED CHECK
(PLEASE DO NOT SEND A DEPOSIT SLIP)

Please automatically charge my Student insurance premiums to my account identified below for this entire policy year.

VISA DISCOVER MASTERCARD AMEX

Credit/Debit Card Number _____ Expires: _____

Last 3 numbers on the reverse side of the credit card. Located within the signature box _____ (For Authorization Purposes)

Print name of cardholder _____

Cardholder phone number _____

Amount authorized to debit _____ for Student Health Insurance.

Cardholder signature _____
Today's Date _____

FOR HOME OFFICE USE ONLY
BANK TRANSIT NUMBER _____
DEPOSITOR'S ACCOUNT NUMBER _____

**SAINT XAVIER UNIVERSITY
ACCIDENT AND SICKNESS CARD 2013-2014
COMPANION LIFE INSURANCE COMPANY**

Please Print Legibly

Student's Name _____
(First) (M) (Last)

Student I.D. # _____

Billing Address: Street _____ Apt. No. _____

City _____ State _____ Zip _____

Male Female Date of Birth _____

Telephone No. _____

E-mail Address (IMPORTANT!) _____

Do you have any other medical insurance? YES NO.

If yes, name of insurance company: _____

Spouse's Name _____

Date of Birth (mm/dd/yy) _____

Social Security # _____

Child _____ Date of Birth (mm/dd/yy) _____

Social Security # _____

Child _____ Date of Birth (mm/dd/yy) _____

Social Security # _____

I do not wish to participate and hereby waive all student health insurance benefits.

I wish to enroll in the Student Insurance Plan checked below. My check or money order for the amount shown is attached.

Make check or money order payable to **Student Insurance Plan.**
Mail this enrollment card along with premium to:
Post Office Box 189, Libertyville, IL 60048

I wish to have my student account charged for the insurance term selected below.

	Annual	Fall Only	
Student Only	<input type="checkbox"/> \$1,476	<input type="checkbox"/> \$ 596	
Additional for Spouse	<input type="checkbox"/> \$2,862	<input type="checkbox"/> \$1,136	
Additional for each Child	<input type="checkbox"/> \$2,259	<input type="checkbox"/> \$ 902	
		New	
	Spring & Summer	Summer	Monthly
Student Only	<input type="checkbox"/> \$ 922	<input type="checkbox"/> \$375	<input type="checkbox"/> \$134
Additional for Spouse	<input type="checkbox"/> \$1,766	<input type="checkbox"/> \$707	<input type="checkbox"/> \$248
Additional for each Child	<input type="checkbox"/> \$1,399	<input type="checkbox"/> \$563	<input type="checkbox"/> \$198

Note: For term date, see page 4, Periods of Coverage.

*Monthly premium is available for ANNUAL coverage. Premium will be debited on the 11th of each month through July 11, 2014. Your signature below indicates that you are aware that you are purchasing ANNUAL coverage with a MONTHLY automatic payment using your banking or credit account. If you do not desire annual coverage, please select another term of coverage.

*MONTHLY ENROLLEES...Please indicate which month you desire your coverage to begin _____(Month). Initial payment is due upon enrollment. Please complete Automatic Payment Authorization Form.

Please charge my Student Health Insurance: Coverage is not automatic. You must re-enroll in the insurance plan each term.

STUDENT ACCOUNT VISA DISCOVER MASTERCARD AMEX

Credit/Debit Card Number _____

3 or 4 digit security code _____ Expiration Date _____

Print name of cardholder _____

Cardholder signature _____

Please Charge \$ _____ for Student Health Insurance.

Student signature _____

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at www.SaintXavierInsurance.com