

Membership Type: Osteopathic Medical Student

Associate Member (Any student of an allied health care profession associated with one of the American Osteopathic Association recognized College of Osteopathic Medicine school must add a \$70 one time membership fee to the insurance premium)



SOMA College Health Insurance Plan 2009-2010 Enrollment Form

		Mo.	Day	Yr.	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> OMS I <input type="checkbox"/> OMS II <input type="checkbox"/> OMS III <input type="checkbox"/> OMS IV
Social Security No.	Last Name First Initial	Birthdate			Sex	School	Year
Address _____ City _____ State _____ Zip _____		Email Address: _____		Telephone Number () _____	Cell Phone () _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner	

LIST ALL DEPENDENTS TO BE COVERED BELOW

Last Name (if different)	First Name	Initial	M	Sex	F	Mo.	Birthdate Day	Yr.	S.S. #
2. Spouse									
3. Child									
4. Child									

Monthly Premium

	Plan 1 <input type="checkbox"/> Co-Pay Plan	Plan 2 <input type="checkbox"/> High Deductible Plan (HDHP)	<input type="checkbox"/> Vision	<input type="checkbox"/> Dental
<input type="checkbox"/> Student				
<input type="checkbox"/> <30	\$164	\$98	\$16	\$38
<input type="checkbox"/> 30+	\$195	\$116		
<input type="checkbox"/> Spouse Only				
<input type="checkbox"/> <30	\$354	\$198	\$9.30	\$32
<input type="checkbox"/> 30+ (Based on Student's Age)	\$426	\$237		
<input type="checkbox"/> Child(ren)	\$262	\$159	\$16.50	\$43

Total Premium Due: Medical Premium \$ _____ + Vision \$ _____ + Dental \$ _____ = Total Premium Enclosed _____

I am authorizing Mass Marketing Insurance Consultants, Inc. to bill my credit card monthly in the amount of _____ for the premium on the individual(s) and plan selected above. Members selecting the Monthly Automatic Pay Plan Check-O-Matic Option must send 2 checks; the first check equal to the monthly payment payable to Mass Marketing Insurance Consultants, Inc. and the 2nd check marked "void" and unsigned. The Monthly Automatic Pay Plan form must also be completed.

Associate Members must also add a one time fee of \$70.00 to the insurance premium.

I want my coverage to start _____ (Enrollment forms received after the 15th of the month will be effective the 1st of the following month)
Mo. Date Year

STUDENT'S SIGNATURE

DATE

Underwritten By: Medical – UnitedHealthcare Insurance Company
Dental - United Concordia Insurance Company
Vision - Vision Service Plan

Administered By: Mass Marketing Insurance Consultants, Inc.
P.O. Box 95
Orland Park, IL 60462

09-NRL (SOMA)

Questions? Call Toll-Free (800) 349-1039