

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 apply for SOMA Membership – www.studentdo.com)



SOMA College Health Insurance Plan 2010-2011 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)	Vision <input type="checkbox"/>	Dental <input type="checkbox"/>
<input type="checkbox"/> Student				
<input type="checkbox"/> <30	\$175	\$104	\$16	\$38
<input type="checkbox"/> 30+	\$208	\$123		
<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.

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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 – United States Fire 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**

NY Residents – Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

All Other States – Fraud Warning: Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

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