

ENROLLMENT / WAIVER FORM
THOMAS JEFFERSON NATIONAL ACCELERATOR FACILITY
STUDENTS, GRADUATE STUDENTS,
GRADUATE RESEARCH ASSISTANTS, POST DOCTORAL RESEARCHERS
ACCIDENT & SICKNESS INSURANCE PLAN
October 1, 2015 – September 30, 2016
Policy GLMN0117308A

YOUR NAME

(Please Print) _____
(Last) (First) (MI)

Address

(Street) (City) (State) (Zip)

ENROLLMENT [] Please **enroll** me and my dependents, if any, in the Accident and Sickness Insurance Plan. I understand coverage will become effective on the later of October 1, 2015, or the date the Enrollment Form and full premium are received by the ACE American Insurance Company or Program Administrator. The coverage dates for my Dependents' and me will be the same, provided the required premium is paid.

Effective Date: 10/01/2015 Expiration Date: 09/30/2016

Participant:	\$266.00 per month	Total Monthly Premium	_____
Spouse:	\$533.00 per month	Number of Months	_____
Child(ren)	\$374.00 per month	Total Premium Due	_____

Make all checks payable to: ACE American Insurance Company

DEPENDENT INFORMATION (IF ANY ENROLLED)

Name _____ Relationship _____ Date of Birth _____

Name _____ Relationship _____ Date of Birth _____

WAIVER [] I wish to **waive** enrollment in the Accident & Sickness Insurance Plan due to the fact that I am covered by:

Name of Insurance Company _____ Policy # _____

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 subjects such person to criminal and civil penalties.

My signature below certifies that I have read and understand the brochure and agree to accept the terms and conditions stated therein.

Signature _____ Date: _____

DELIVER TO: Jefferson Lab International Services Office
628 Hofstadter Rd., Suite 2
Newport News, VA 23606