❑ NEW
❑ RENEWING

80

USI Student Insurance Medical ID#

Underwritten by United Concordia Dental
FULLER THEOLOGICAL SEMINARY STUDENT DENTAL PLAN

2019-2020 DOMESTIC & INTERNATIONAL STUDENT ENROLLMENT FORM

STUDENT & DEPENDENT ENROLLMENT FORM

STUDENT'S NAME	LAST / SURNAME		
	FIRST NAME		MIDDLE INITIAL
STUDENT I.D. #	DATE OF BIRTH (Month, Day, Year)	SOCIAL SECURITY # (U.S. Citizens and Permanent Residents only)	
U.S. MAILING ADDRESS (Use school address if none)	STREET		APARTMENT #
CITY	STATE	ZIP	
PHONE #	EMAIL ADDRESS **(REQUIRED)**		
Please check appropriate box: ❑ FEMALE ❑ MALE	**Please check appropriate box:** ❑ SINGLE ❑ MARRIED/DOMESTIC PARTNER	**Please check appropriate box:** ❑ DOMESTIC ❑ INTERNATIONAL	
VISA TYPE *(if applicable)*	HOME COUNTRY: *(if applicable)*		

PLEASE LIST DEPENDENTS TO BE INSURED BELOW. DEPENDENT COVERAGE IS AVAILABLE ONLY IF THE STUDENT IS ALSO ENROLLED IN THE PLAN.

LAST / SURNAME	FIRST NAME	MIDDLE INITIAL	GENDER	DATE OF BIRTH (Month/Day/Year)	SOCIAL SECURITY OR TAX I.D. # *(U.S. Citizens and Permanent Residents only)*
SPOUSE/DOMESTIC PARTNER:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		
CHILD:			❑ F ❑ M		

Benefits and claims questions:
United Concordia Dental
(866) 357-3304
www.unitedconcordia.com

Benefits provided by:
United Concordia Dental
Group #898514001

Eligibility, coverage, enrollment, and general questions:
USI Student Insurance
(800) 853-5899
Mon - Fri, 8am-5pm PST
https://studentinsurance.usi.com

Fuller Student Health Insurance Office:
(626) 584-5438
shi@fuller.edu

Plan brokered by:
USI Insurance Services, LLC
CA License No. 0G11911
https://studentinsurance.usi.com

You can view the standard Summary of Benefits & Coverage (SBC) which is required by Health Care Reform. It summarizes your coverage in a format that all insurance companies now use. To view your plan SBC, go to: *https://studentinsurance.usi.com* and select Find Your School's Plan or call **800-853-5899**.

PLEASE SEE OTHER SIDE FOR RATES AND PAYMENT INFORMATION. YOU MUST COMPLETE BOTH SIDES OF THIS ENROLLMENT FORM.

PAYMENT IN FULL IS REQUIRED FOR THE TERM PURCHASED

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PROGRAM COSTS				
Terms of Coverage	**FALL** 10/1/19 - 12/31/19	**WINTER** 1/1/20 - 3/31/20	**SPRING** 4/1/20 - 6/30/20	**SUMMER** 7/1/20 - 9/30/20
Enrollment Deadline	**12/31/19**	**3/31/20**	**6/30/20**	**9/30/20**
Student only	❑ $56.27	❑ $56.27	❑ $56.27	❑ $56.27
Student & One Dependent (Age 0-25)	❑ $95.11	❑ $95.11	❑ $95.11	❑ $95.11
Student & Two or More Dependents (Age 0-25)	❑ $145.16	❑ $145.16	❑ $145.16	❑ $145.16

Rates include premium payable to United Concordia Dental, as well as administrative fees payable to Fuller Theological Seminary and USI Student Insurance.

If you have questions or prefer enrolling via phone please contact USI directly at (800) 853-5899.

PAYMENT METHOD (Remit in US Funds Only)

NOTE: If we are unable to process your payment (due to insufficient funds, closure of account, etc.), you and/or your dependents' insurance coverage will be terminated retroactive to the effective date of the enrolled term and you will be responsible for any claims that you've incurred. Premium is non-refundable unless you are found to be ineligible for the plan.

❑ **Check/Money Order –** MAKE CHECKS PAYABLE TO: USI Insurance Services National, Inc.

❑ **Credit Card:** ❑ Visa ❑ MasterCard ❑ Discover

Credit Card Account Number: | Expires (month, year):

Cardholder's Name:

(Enter/Print Cardholder's name exactly as it appears on card.)

Send enrollment form, dependent documentation, and payment by mail, email or fax to:
USI Student Insurance, 10940 White Rock Road, 2nd Floor, Rancho Cordova, CA 95670 • sienrollment@usi.com • Fax (877) 612-7966

COVERAGE IS NOT AUTOMATICALLY RENEWED. Coverage will end on the last date specified in the plan you select, unless you enroll to continue insurance for an additional term. Premiums are calculated based on the plan term and will not be pro-rated. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

PLEASE READ CAREFULLY AND SIGN BELOW - REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions: **IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT UNITED CONCORDIA DENTAL REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF DENTAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT.** California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." **THIS MEANS THAT YOU AND UNITED CONCORDIA DENTAL ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH DENTAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.**

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements and I have read and understand the Plan Brochure. My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept as applicable to me the terms and conditions stated therein. It also authorizes my school to provide USI Student Insurance with required information necessary in the event of a medical emergency.

SIGNATURE OF STUDENT _____ DATE _____

USI INSURANCE SERVICES PRIVACY INFORMATION

We know that your privacy is important to you and we strive to protect the confidentiality of your personal information. We do not disclose any personal information about our plan participants, except as permitted or required by law (e.g., information you provide to us may be shared with your school to process your insurance transaction). To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. You may obtain a detailed copy of our privacy policy through your school or by calling us at (800) 853-5899 or by visiting us at *http://www.usi.com/privacy*.