



Florida State University Fall 2014
Post Doctoral Fellow and Visiting Scholar Medical Insurance Plan Application

Applicant's Name (Last, First, Middle) Please Print all Entries except your signature.		Date of Birth (mmddyyyy)
Permanent U.S. Address (Street, City, State, Zip)		E-mail Address
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Phone #: ()	Applicant SSN temporary SSN
Effective Date: This is the date you want your insurance to begin.	Coverage: <input type="checkbox"/> <input type="checkbox"/> Quarterly <input type="checkbox"/> August 15- November 13 <input type="checkbox"/> November 14- December 31 <input type="checkbox"/>	Applicant Studies: <input type="checkbox"/> Post Doctoral Fellow <input type="checkbox"/> Visiting Scholar International Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No

Dependents	Last Name	First Name	Male/ Female	Date of Birth (mmddyyyy)
Spouse				
Child				
Child				

Select boxes. Add up premium of all selected boxes for premium total.	Domestic Premium Rates				International Premium Rates (J-1 and F-1 visa holders)			
		1st Qtr	2d Qtr			1st Qtr	2d Qtr	
	Post Doctoral Fellow/Scholar		\$420	\$220.80			\$462	\$242.88
Dependent Spouse		\$991	\$521.28			\$1289	\$678.24	
Dependent Child		\$532	\$279.84			\$597	\$314.40	
Dependent Children		\$846	\$444.96			\$964	\$506.88	

Payment may be made by VISA or MasterCard credit or debit card. Check or money order must be mailed to the address on the instruction sheet.

Premium total	\$
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Credit Card Information -

Put your credit card number information below													
Expiration Date: Month/Year				Signature of Applicant						Date			