FrontierMEDEX
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AMERICAN UNIVERSITY IN CAIRO
2013-2014

Policy: GLMN 01173662, Underwritten By: ACE American Insurance Company, Philadelphia, PA
Enrollment Form for Dependents' Coverage (Please Print or Type)

Your (Covered Person) Last Name | First Name | Middle Initial

Street – Permanent Mailing Address

City | State | Country | Code

I wish to enroll my Eligible Dependents, named below for coverage under the Plan. Please refer to your American University in Cairo Plan for a summary of the coverage available to Eligible Dependents.

I understand that insurance becomes effective only when this Enrollment Form and full premium payment have been received by FrontierMEDEX, Inc. at the address shown below.

Signature | Date (MM/DD/YY)

Mark appropriate boxes		**Monthly Premium**
☐	Spouse less than age 25	$60.45
☐	Spouse age 25-34	$80.45
☐	Spouse age 35-49	$98.45
☐	Spouse age 50-64	$125.45
☐	Spouse age 65 and over	$158.45
☐	One Child	$54.45
☐	Two or More Children	$106.45
	Total Monthly Premium	$_____
	Number of Months	X_____
	Total Premium Due	**$**_____

Dependents' coverage will become effective and terminate on the same dates as the Covered Person, provided the required premium is paid. Indicate the requested effective date for the dependent(s). Termination of coverage must coincide with the Covered Person's termination of coverage.
Effective Date: _____ (MM/DD/YY) Termination Date_____(MM/DD/YY)

I wish to extend my own coverage to include my following dependents (spouse and/or unmarried children under age 19)

Dependent Name	SS#	DOB (MM/DD/YY)	Relationship to Covered

Payment Method (US Funds only): ___ Check(payable to MEDEX Insurance Services); ___MasterCard/Visa
Card#__ __ __ __-__ __ __ __-__ __ __ __-__ __ __ __Security Code_____Expiration Date _____(MM/YY)
Name on Card_____ Signature X_____

Any person who knowingly 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 conditional stated therein.

Signature_____ Date_____ (MM/DD/YY)

Send Payment and this form to:
Fax: 410-583-8244
Phone: 410-583-2595, 800-586-0753

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