## 2017/18 Consolidated Health Plans
## Student Health Supported Graduate Insurance Enrollment Form

Please complete both sections and return to the Student Insurance Office by September 1, 2017 or fax to 906-487-3220

Michigan Tech ID M _____

Student Name: _____
*Last* *First* *Middle Initial*

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ - _____ Email Address: _____

**Notice to Student:** Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1. She/he has carefully read the certificate and elects to enroll as indicated in this enrollment card; 2. Rates are pro-rated other than as listed on this enrollment card; 3. She/he must meet the eligibility requirements for this coverage as described in the certificate; 4. If it is later determined that the student is not eligible, the premium will be refunded. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

Students Signature: _____ Date: _____

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## Graduate Student Health Insurance Payroll Deduction Authorization

Name: _____ M# _____

Payroll Deduction Code: G S H Goal: $ 627. 0 0

Bi-Weekly Deduction Amount: $ 78.38 Start Date: 0 8/2 7/2 0 1 7

I hereby authorize Michigan Tech to deduct the amount stated above from my pay and any balance due upon my termination from the University. There will be eight deductions during fall term for those students supported via assistantship. The full amount will be deducted from fellowship student's second check for the semester.

Signature: _____ Date: _____

06/30/17