GeoBlue, 933 First Avenue, King of Prussia, PA 19406
1.855.682.7965 | 1.610.254.5300 | fax 1.610.482.9953

University of Colorado - Dependents

GROUP INSURANCE ENROLLMENT FORM FOR DEPENDENTS

THIS FORM IS **ONLY FOR DEPENDENTS** OF PARTICIPANTS CURRENTLY INSURED UNDER THE BUSINESS TRAVELER PLAN FOR UNIVERSITY OF COLORADO.

PLEASE PRINT – ANSWER ALL QUESTIONS. YOUR APPLICATION WILL BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.

STUDENT / FACULTY / STAFF - PERSONAL INFORMATION

Name of Participant: _____ (First Name) _____ (Middle Name) _____ (Last Name) **Gender:** ☐ M ☐ F **Date of Birth:** _____ MM DD YYYY

Mailing Address: _____ (Street) _____ (Room/Apt. #) _____ (City) _____ (State) _____ (Zip Code)

Home Phone: _____ **Mobile Phone:** _____ **Email Address:** _____

What is your Home Country?: _____ **Student ID (if applicable):** _____

Participant GeoBlue Certificate Number: _____

COVERAGE INFORMATION

I WISH TO ENROLL FOR INSURANCE UNDER THE TERMS OF THE MASTER POLICY AS FOLLOWS:

Coverage Type: ☐ Spouse Only ☐ Child Only ☐ Children ☐ Family

I want my coverage to begin on _____ MM DD YYYY **and to end on** _____ MM DD YYYY

	Spouse	Child (per child)
Daily Premium Rates: (Valid 10/01/2024 to 09/30/2025)	**$5.93**	**$5.93**

Premium for Spouse/Children	$
Multiply by Days of Coverage	x
Total Premium Enclosed:	$

Names of Spouse and Children to be insured:

			Gender	Date of Birth
Spouse:	(First Name)	(Last Name)	☐ M ☐ F	MM DD YYYY
Child:	(First Name)	(Last Name)	☐ M ☐ F	MM DD YYYY
Child:	(First Name)	(Last Name)	☐ M ☐ F	MM DD YYYY
Child:	(First Name)	(Last Name)	☐ M ☐ F	MM DD YYYY

Beneficiary Information for Accidental Death & Dismemberment Coverage

Beneficiary*: _____ (Name and Relationship)

***Note:** The Participant will be the beneficiary for any insured dependent's loss of life

PAYMENT INFORMATION

*****REMITTANCES ACCEPTED IN U.S. FUNDS ONLY*****

METHOD OF PAYMENT: ☐ Check ☐ Money Order

I certify that the information on this Enrollment Form is true and correct to the best of my knowledge. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signature of Participant: _____

Make checks payable to **"Worldwide Insurance Services"** and mail with this completed enrollment form to:

Worldwide Insurance Services, 933 First Avenue, King of Prussia, PA 19406

The coverage will be effective at 12:01 A.M. on the day which is at least 24 hours after the time and date of the receipt of the enrollment form.