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: ______________________ **Gender:** ☐ M ☐ F **Date of Birth:** ________
(First Name) (Middle Name) (Last Name) 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 ________ **and to end on** ________
MM DD YYYY MM DD YYYY

	Spouse	Child	Children
Daily Premium Rates: (Valid 10/01/2023 to 09/30/2024)	**$4.74**	**$4.74**	**$4.74**

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

Names of Spouse and Children to be insured:

	Name	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.