

PLEASE COMPLETE
THIS FORM IN BLOCK
LETTER PRINT
USE BLACK INK

THE MEGA LIFE AND HEALTH INSURANCE COMPANY
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS



2006-2007
SOUTH DAKOTA SYSTEM

2006-53-1

SOCIAL SECURITY # _____ - _____ - _____ or SCHOOL ID# _____
 PRIMARY INSURED STUDENT NAME: _____
 Last (Family) Name

 First (Given) Name Middle Initial

GENDER: Male Female DATE OF BIRTH: _____ - _____ - _____ EXPECTED DATE OF GRADUATION: _____ - _____
 Check one Month Day Year Month Year

PERMANENT ADDRESS: _____
 House/Building Number and Street Name

 Apt. or P.O. Box # or Rural Route City County State ZIP Code

MAILING ADDRESS: _____
 House/Building Number and Street Name

 Apt. or P.O. Box # or Rural Route City County State ZIP Code

Complete information below for Dependents to be insured. Dependent coverage is available only for Dependents of Students insured under the Plan.

SPOUSE: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
 Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
 Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
 Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
 Social Security Number (Check One) Month Day Year

CHILD: _____ - _____ - _____ Male Female Date of Birth : _____ - _____ - _____
 Social Security Number (Check One) Month Day Year

_____ - _____ - _____
 First (Given) Name M/I Last (Family) Name

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) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 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.**

STUDENT'S SIGNATURE: _____ DATE: _____

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CAMPUS LOCATION: (PLEASE CHECK THE SCHOOL YOU ATTEND)

- Black Hills State University 2006-80-1
Dakota State University 2006-220-1
Northern State University 2006-1228-1
South Dakota School of Mines & Technology 2006-232-1
South Dakota State University 2006-263-1
University of South Dakota 2006-221-1
Center for Public Higher Education 2006-1381-1

I elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. Below are the choices I have made.

PLEASE CHECK ALL APPROPRIATE BOXES

INSURED CATEGORY:

- DOMESTIC
INTERNATIONAL
ATHLETES

Table with 5 columns: ID CODES, Annual (A-), Fall (F-), Spring(G-), Spring/Summer (J-). Rows include Student Under Age 25, Student Age 25 - 29, Student Age 30 & Older, Spouse, and Each Child.

Table with 3 columns: ID CODES, Summer (S-), Monthly (MX). Rows include Student Under Age 25, Student Age 25 - 29, Student Age 30 & Older, Spouse, and Each Child.

OPTIONAL INTERCOLLEGIATE SPORTS COVERAGE (STUDENTS ONLY)

AVAILABLE ONLY TO THOSE STUDENTS WHO ARE ENROLLED IN THE BASIC PLAN

Annual (A-)

- F. Intercollegiate Football \$ 377.00
G. All other sports \$ 251.00

EFFECTIVE / EXPIRATION PERIODS:

- Annual 08-15-2006 to 08-14-2007
Fall 08-15-2006 to 01-10-2007
Spring 01-10-2007 to 05-06-2007
Spring/Summer 01-10-2007 to 08-14-2007
Summer 05-06-2007 to 08-14-2007

ONLINE SERVICES: Please Visit our Website at www.studentresources.com to buy insurance online or to view and print Brochures, Enrollment Cards (printable using Adobe Acrobat), Coverage Receipts, ID Cards, Claims Status and other services.

Payment Instructions: Make check or money order payable to Student Insurance in US dollars (no cash or currency) or refer to the Charge Card Authorization to charge your premium to Visa or MasterCard. Mail this enrollment card along with premium payment to Student Insurance, PO Box 809026, Dallas TX 75380-9026. Your cancelled check or credit card billing is your only receipt and notification of coverage. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.

CHARGE CARD AUTHORIZATION PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ [blank] [] VISA or [] MASTERCARD # [blank] Expiration Date [blank] - [blank] / [blank] Month Year

AUTHORIZED SIGNATURE [blank] DATE [blank]

OR PAID BY CHECK # [blank] AMOUNT PAID \$ [blank]