

**VOLUNTARY ENROLLMENT FORM – FOR ATHLETIC STUDENTS ONLY
COLUMBIAN LIFE INSURANCE COMPANY OF NEW YORK
FARMINGDALE STATE COLLEGE
ACCIDENT & SICKNESS MEDICAL EXPENSE BENEFITS 2009-2010**

Student's Name: _____ SS#: _____
 (Please Print) (Last) (First) (MI)
 Home Address: _____
 (Street) (City) (State) (Zip)

ANNUAL COVERAGE – 8/27/09 to 8/27/10 I have requested that **\$500.00** be added to my balance due for the annual insurance premium.
 SPRING SEMESTER – 1/25/10 to 8/27/10 I have requested that **\$298.00** be added to my balance due for the spring insurance premium.

Dismissal from any sport team sport, either voluntary or due to disciplinary reasons, shall result in the student's personal responsibility for the payment of the health insurance premium. At the conclusion of the try out period, failure to make any sport team, shall result in the student's personal responsibility for payment of the health insurance premium.

Signature: _____ Date: _____

PAYMENT IN FULL IS DUE AT TIME OF ENROLLMENT

RETURN TO: Farmingdale State College, Student Account Office no later than October 31, 2009 for annual enrollment or March 14, 2010 for spring enrollment.

Policy No. # 31-67-0028-029-002-9

The following **summary** highlights the Accident and Sickness Insurance Plan for the students of Farmingdale State College. **Please consult the policy brochure available at the Auxiliary Services Office and Student Health & Wellness Center for a complete description of the policy benefits and exclusions.**

ACCIDENT EXPENSE BENEFIT This plan provides benefits for students while participating in school sponsored activities

Aggregate Maximum: \$5,000 per Injury
 Covered Percentage: 100% of Covered Charges
 Deductible: \$0

Benefits Covered:

(a) hospital room and board; (b) miscellaneous hospital; (c) inpatient and outpatient surgery; (d) inpatient and outpatient anesthetist; (e) inpatient and outpatient Doctor visits; (f) consultation; (g) licensed nurse; (h) hospital outpatient department; (i) emergency room; (j) diagnostic x-ray and laboratory tests; (k) outpatient prescription drug; (l) ambulance/taxi; (m) durable medical equipment, prosthetic appliances and orthotic devices; and (n) other expenses incurred for the treatment of an Injury.

All intercollegiate sport injuries except Football and Hockey are covered on the same basis as any other Injury.

ACCIDENTAL DEATH & DISMEMBERMENT EXPENSE BENEFIT

Principle Sum: \$2,500

SICKNESS EXPENSE BENEFIT This plan provides 24 hour world wide coverage for Covered Sicknesses as allocated below:

Aggregate Maximum: \$25,000 per Sickness
 Deductible: \$0

The following Sickness Benefits are allocated as follows:

| | |
|--|---|
| Hospital Room & Board Expense Benefit: | \$250.00 per day |
| Miscellaneous Hospital Expense Benefit: | \$500.00 per day |
| Surgical Expense Benefit: | \$1,500 per Sickness |
| Anesthesia Expense Covered Percentage: | 25% of the amount paid under the Surgical Expense Benefit |
| Assistant Surgeon Expense Covered Percentage: | 25% of the amount paid under the Surgical Expense Benefit |
| In-Hospital Doctor's Fees and Medical Expense Benefit: | \$50.00/visit; 1 visit per day |
| Consultant Visit Expense Benefit (Inpatient and Outpatient): | \$150.00 per Sickness for the 1 st visit; then \$75.00 per visit up to 3 visits |
| Outpatient Doctor's Office Visit Expense Benefit: | \$50.00/visit; 20 visits per Sickness. A visit to the Student Health Center must serve as the 1 st visit unless the college is in recess or the student is away from campus. |
| Hospital Outpatient Department Expense Benefit: | \$500.00 per Sickness |
| Emergency Room Expense Benefit: | \$300.00 per Sickness |
| Outpatient Diagnostic X-ray & Lab Test Benefit: | \$300.00 per Sickness |
| Abortion Expense Benefit: | \$500.00 |
| Home Health Care Expense Benefit: | |
| Covered Percentage: | 75% of Covered Charges |
| Deductible: | \$50.00 per Sickness |
| Benefit: | 40 visits per calendar year |
| Ambulance/Taxi Expense Benefit: | \$100.00 per Sickness |
| Emergency Dental Expense Benefit: | |
| Extraction of impacted tooth: | \$150.00 |
| Initial endodontic visit: | \$100.00 |
| Emergency Extraction of tooth: | \$100.00 |
| Emergency filling - per surface: | \$ 25.00, \$200 Policy year maximum |
| Outpatient Mental & Nervous Expense Benefit: | Paid under Mandated Benefits, as any other sickness |

Please consult brochure for a complete listing of schedule of benefits, state mandated benefits, terms, conditions and exclusions and limitations