

PREMIUMS: (select all enrollment periods, calculate combined total, and refer to payment section below)

INJURY AND SICKNESS INSURANCE COVERAGE – MEDICAL PREMIUMS PER PERIOD (if adding a dependent, premiums are cumulative)

	Coverage Dates	ENROLLMENT DEADLINE	Student	Spouse	One Child	2+ Children	TOTAL
Annual	8/1/22 – 7/31/23	9/20/2022	<input type="checkbox"/> \$2,688	<input type="checkbox"/> \$2,688	<input type="checkbox"/> \$2,688	<input type="checkbox"/> \$5,376	
Fall	8/1/22 – 12/31/22	9/20/2022	<input type="checkbox"/> \$1,120	<input type="checkbox"/> \$1,120	<input type="checkbox"/> \$1,120	<input type="checkbox"/> \$2,240	
Spring + Summer	1/1/23 – 7/31/23	1/31/2023	<input type="checkbox"/> \$1,568	<input type="checkbox"/> \$1,568	<input type="checkbox"/> \$1,568	<input type="checkbox"/> \$3,136	
Summer	5/1/23 – 7/31/23	5/31/2023	<input type="checkbox"/> \$672	<input type="checkbox"/> \$672	<input type="checkbox"/> \$672	<input type="checkbox"/> \$1,344	

OPTIONAL DENTAL AND VISION COVERAGE – ANNUAL PREMIUMS (premiums are combined)

	Coverage Dates	ENROLLMENT DEADLINE	Student	Student + Spouse	Student + Child(ren)	Student + Family	TOTAL
Dental	8/1/22 – 7/31/23	9/20/2022	<input type="checkbox"/> \$230.32	<input type="checkbox"/> \$460.65	<input type="checkbox"/> \$619.00	<input type="checkbox"/> \$904.65	
Vision	8/1/22 – 7/31/23	9/20/2022	<input type="checkbox"/> \$144.72	<input type="checkbox"/> \$274.44	<input type="checkbox"/> \$321.84	<input type="checkbox"/> \$452.64	

COMBINED TOTAL: _____

PAYMENT: (select payment type and complete related section)

- CHECK**, payable to John H. Hildreth, CLU, LLC. Check # _____
- MONEY ORDER**, payable to John H. Hildreth, CLU, LLC. Order # _____
- E-CHECK**, 0.75% fee applies. Complete this section: Account Type (checking, savings, business): _____
Routing Number (9 Digit): _____ Bank Account #: _____
Account Holder Name: _____ Amount (Combined Total + 0.75% processing fee): _____
Account Holder Signature: _____ Date: _____
- CREDIT/DEBIT CARD** (Visa, Discover, or Mastercard), 2.5% fee applies. Complete payment authorization:
Card Number: _____ CID Code (3-digit code on back of card): _____
Expiration Date: _____ Total Charge (Combined Total + 2.5% processing fee): _____
Billing Address (if different from page 1): _____
Cardholder Signature: _____ Date: _____

WHERE TO SEND COMPLETED FORM:

1. **MAIL** enrollment form with check or money order payable to John H. Hildreth, CLU, LLC, or complete payment section for credit card or e-check payment. Mailing address: John H. Hildreth, CLU, LLC
Attn: Student Health Insurance
10259 Kingston Pike
Knoxville, TN 37922
2. **FAX** enrollment form to 865-694-0362. This requires payment by credit card or e-check.
3. **EMAIL** enrollment form to studenthealth@hildrethins.com. This requires payment by credit card or e-check.
4. **ONLINE** enrollment can be completed by visiting www.studenthealthprograms.com. Credit card payment is required.

Your cancelled check, credit card billing, or email confirmation is your receipt and notification of coverage.

Payment is due in full at time of enrollment. Optional Dental & Vision Coverage is available during Fall/Annual enrollment and must be purchased on an annual basis. It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.