

**ENROLLMENT / WAIVER FORM**  
**THOMAS JEFFERSON NATIONAL ACCELERATOR FACILITY**  
***STUDENTS, GRADUATE STUDENTS,***  
***GRADUATE RESEARCH ASSISTANTS, POST DOCTORAL RESEARCHERS***

**ACCIDENT & SICKNESS INSURANCE PLAN**  
**October 1, 2011 – October 1, 2012**  
**Policy GLM N0117308A**

**YOUR NAME**

(Please Print) \_\_\_\_\_  
(Last) (First) (MI)

**Address**

\_\_\_\_\_  
(Street) (City) (State) (Zip)

**ENROLLMENT**  Please **enroll** me and my dependents, if any, in the Accident and Sickness Insurance Plan. I understand coverage will become effective on the later of October 1, 2011, or the date the Enrollment Form and full premium are received by the ACE American Insurance Company or Program Administrator. The coverage dates for my Dependents' and me will be the same, provided the required premium is paid.

Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Participant: \$224.00 per month Total Monthly Premium \_\_\_\_\_

Spouse: \$449.00 per month Number of Months X \_\_\_\_\_

Child(ren) \$315.00 per month  
Total Premium Due = \_\_\_\_\_

**Make all checks payable to: MEDEX Insurance Services, Inc.**

**DEPENDENT INFORMATION (IF ANY ENROLLED)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Date of Birth \_\_\_\_\_

**WAIVER**  I wish to **waive** enrollment in the Accident & Sickness Insurance Plan due to the fact that I am covered by:

Name of Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**My signature below certifies that I have read and understand the brochure and agree to accept the terms and conditions stated therein.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**DELIVER TO:**

Jefferson Lab International Services Office  
628 Hofstadter Rd., Suite 2  
Newport News, VA 23606

Program Administered By: CMI Insurance, FrontierMEDEX, P.O. Box 19056, Baltimore, MD 21284 Phone 410-583-2595, 800-586-0753, Fax 410-583-8244