

Florida Student University Plan

Humana

Dental - Vision

Enrollment Form

Student: _____
Last Name First Name MI

Permanent US
Mailing Address: _____
Address - Number & Street Apt. No.
_____ City State ZIP

Phone Number: _____ E-Mail: _____

Student Date of Birth: ___ / ___ / ___ Sex ____

Student Social Security Number: _____

Name of School: _____

Annual Dental Plan: \$100.00

Annual Vision Plan: \$ 38.00

Total Remitted: _____

Requested Effective Date: _____

Completed enrollment forms, with premium, received by Collegiate Risk Management by the 15th of the month will become effective on the 1st of the following month or on the requested effective date (if later).

Payment Instructions: Place a checkmark before the amount you are enclosing. **Please make check payable to Collegiate Risk Management in U.S. dollars and mail to:**

**Collegiate Risk Management
110 Athens Street
Tarpon Springs, FL 34689**