933 First Avenue King of Prussia, PA 19406
PH# 1.855.682.7965● Fax 1.866.281.1643 ● www.geo-blue.com

University of Colorado

GeoBlue Traveler Insurance – Dependent Enrollment Form

Please Print – Answer All Questions. Your application will be returned if all questions are not answered.

PERSONAL INFORMATION

EMPLOYEE Name: _____ **Gender:** ☐ M ☐ F **Date of Birth:** _____
(First Name) (Middle Name) (Last Name) MM DD YYY

Mailing Address: _____
(Street) (Room/Apt. #) (City) (State) (Zip Code)

Home Phone: _____ **Mobile Phone:** _____ **Primary Email :** _____

Secondary Email : _____

Employee ID: _____ **What is your Destination/Host Country(s)?:** _____

Names of Spouse and Children to be insured, if applicable* **Gender** **Date of Birth**

Spouse: _____ ☐ M ☐ F _____
(First Name) (Last Name) MM DD YYYY

Child: _____ ☐ M ☐ F _____
(First Name) (Last Name) MM DD YYYY

Child: _____ ☐ M ☐ F _____
(First Name) (Last Name) MM DD YYYY

Child: _____ ☐ M ☐ F _____
(First Name) (Last Name) MM DD YYYY

COVERAGE INFORMATION

I wish to enroll for insurance under the terms of the Master Policy as follows:

Coverage Type: ☐ Spouse ☐ Dependent Child

I want my coverage to begin _____ **and to end on** _____ = # of Days of Coverage _____
(Valid 10/01/2021 to 09/30/2022)
MM DD YYYY MM DD YYYY

*Example: 10/01/2020 to end on 10/20/2020 = 20 Days of Coverage

Daily Premium Rates: **Spouse** **Child**

(Valid 10/01/2021 to 09/30/2022) $4.74 $4.74

		Example
Premium for Spouse	$_____	$_____$4.74____
Premium per Child	$_____	$_____$4.74____
Premium subtotal	_____	$_____$9.48____
Multiply by Days of Coverage	X _____	X _____20_____
Total Premium Enclosed	$_____	$_____189.60____

PAYMENT INFORMATION

REMITTANCES ACCEPTED IN U.S. FUNDS ONLY

METHOD OF PAYMENT: ☐ Check ☐ Money Order Credit Cards: ☐ MasterCard ☐ VISA ☐ American Express ☐ Discover

If paying by credit card, I authorize GeoBlue to bill my account for the Total Premium listed above

CARD#: _____ **EXP. DATE:** _____

Name as it appears on card: _____ _____
(Signature of Cardholder)

CVV Code: _____ **Zip Code (where the cc gets billed):** _____

I certify that the information on this Enrollment Form is true and correct to the best of my knowledge. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signature of Employee/ Spouse/Guardian: _____
Date

Make checks payable to **"Worldwide Insurance Services"** and mail with this completed enrollment form to:

Worldwide Insurance Services, 933 First Avenue King of Prussia, PA 19406

If paying by Credit Card, Fax to 1.866.281.1643

The coverage will be effective at 12:01 A.M. on the day which is at least 24 hours after the time and date of the receipt of the enrollment form.