

INSURANCE FOR STUDENTS – GLOBAL CARE ESSENTIAL ENROLLMENT FORM \$100 Deductible Plan

International Student Injury and Sickness Program

Underwritten by Student Resources (SPC) a United Healthcare Group Company Policy # 2017-203140-91

PLEASE PRINT CLEARLY – FAILURE TO PROVIDE ALL INFORMATION MAY DELAY OR VOID YOUR INSURANCE

STUDENT/SCHOLAR Last Name: _____

First Name: _____

Middle Initial: _____

Student I.D #: _____

I am a Student OR Scholar with F1 J1 OTHER _____

Date of Birth (Month/day/year): _____

Male Female

Mailing Address: _____

City: _____

State: _____

Zip: _____

Phone # () _____

EMAIL ADDRESS: _____

NAME OF COLLEGE OR UNIVERSITY: _____

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan. Coverage must be purchased at the time of primary insured's enrollment or within 30 days of birth/marriage or arrival in country

Spouse Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) ____/____/____ SS#: - - Gender Male Female

CHILD 1 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) ____/____/____ SS#: - - Gender Male Female

CHILD 2 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) ____/____/____ SS#: - - Gender Male Female

PREMIUM - Rates are Valid for coverage EFFECTIVE After 7/1/2016 COVERAGE CANNOT EXTEND BEYOND 9/30/2017

Effective date (month/day/year): _____

ANNUAL RATES	DAILY RATES (90 DAY MIN)	PREMIUM CALCULATION
STUDENT/SCHOLAR RATES Age 24 & Under \$ 546.00 Student 25-30 \$ 875.00 Student 31-40 \$ 1,925.00 Student 41-64 \$ 4,453.00 DEPENDENT RATES Spouse \$ 5,392.00 Each Child \$ 2,923.00	STUDENT/SCHOLAR RATES Age 24 & Under \$ 1.51 Student 25-30 \$ 2.40 Student 31-40 \$ 5.28 Student 41-64 \$ 12.20 DEPENDENT RATES Spouse \$ 14.78 Each Child \$ 8.02	TOTAL PREMIUM \$ _____ (ADD STUDENT/SPOUSE/CHILD RATE)

Please include a processing fee per enrollee for credit & debit card payments ONLY \$24 Per Enrollee Annual or \$2 Per Enrollee Per 30 days

METHOD OF PAYMENT:

CHECK MONEY ORDER Make payable to Insurance for Students Credit Card (complete below)

Credit Card Authorization – MasterCard Discover American Express Visa Please bill my card for my insurance premium shown above

Cardholder Name (Last/First) _____

Cardholder Number: | | | | | | | | | | | | | | | | | | | | | | Expiration Date (mo/year) | | .

NOTICE TO STUDENT: Coverage will be effective the date the correct premium is received by the company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing, the student acknowledges the following: 1) He/She has carefully read the brochure and elects to enroll as indicated on this enrollment card; 2) Rates are not pro-rated other than as listed on this enrollment card; 3) He/She meets the eligibility requirements for this coverage as described in the brochure; and 4) If it is later determined that the student is not eligible, the premium will be refunded. **PREMIUM WILL NOT BE REFUNDED EXCEPT FOR INELIGIBILITY OR ENTRANCE INTO THE ARMED FORCES.**

I understand that I must be an international student enrolled or scholar to purchase this insurance.

Student's Signature: _____

Date: _____

FOR QUESTIONS PLEASE CONTACT:

**INSURANCE FOR STUDENTS INC. – 1690 S. CONGRESS AVE #101, DELRAY BEACH FL 33445
PHONE 800-356-1235 FAX 954-772-0872**

APPLICATIONS CAN BE MAILED TO ADDRESS ABOVE OR IF PAYING BY CREDIT CARD CAN BE FAXED TO 954-772-0872