INSURANCE FOR STUDENTS – PRIME PLUS PLAN ENROLLMENT FORM

International Student Injury and Sickness Program

Underwritten by Student Resources (SPC) a United Healthcare Group Company Policy # 2017-202917-91

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 7/1/2017 COVERAGE CANNOT EXTEND BEYOND 9/30/2018

Effective date (month/day/year):

ANNUAL RATES		DAILY RATES (90 DAY MIN)		PREMIUM CALCULATION
STUDENT/SCHOLAR RATES		**STUDENT/SCHOLAR RATES**		
Age 24 & Under	$1,065.00	Age 24 & Under	$ 2.92	**TOTAL PREMIUM $ ___________**
Student 25-30	$1,520.00	Student 25-30	$ 4.18	(ADD STUDENT/SPOUSE/CHILD RATE)
Student 31-40	$3,315.00	Student 31-40	$ 9.09	
Student 41-64	$6,864.00	Student 41-64	$ 18.81	
DEPENDENT RATES		**DEPENDENT RATES**		
Spouse	$6,785.00	Spouse	$ 18.60	
Each Child	$3,758.00	Each Child	$ 10.30	

Please include a processing fee per enrollee for credit & debit card payments ONLY ☐ $30 Per Enrollee Annual or ☐ $3 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:_ I I I I I I I I I I I I I I I I I _____Expiration Date (mo/year)_________ I ________.

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 AVENUE #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