2009 2010 Care Plan

United HealthCare Insurance Company **2009-202375-91**

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

NAME OF COLLEGE OR UNIVERSITY:

STUDENT/SCHOLAR Last Name:

First Name: Middle Initial:

Social Security # - - OR Student I.D. #

Date of Birth (Month/day/year) [ ] Male [ ] Female

Mailing Address:

City: State: Zip

Phone # ( ) EMAIL ADDRESS:

I am a [ ] Student OR [ ] Scholar with J1 Visa Home Country

[ ] New Applicant OR [ ] Renewal

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 3 MONTH ENROLLMENT IS MINIMUM REQUIRED Rates are Valid for coverage EFFECTIVE After 8/1/2009 COVERAGE CANNOT EXTEND BEYOND 10/31/2010

Effective date (month/day/year): **Number of Months covered:**

MONTHLY RATES – 3 MONTH MININUM ENROLLMENT

STUDENT/SCHOLAR RATES		DEPENDENT RATES	
Age 24 & Under	$ 51.00	Spouse 24 & under	$ 175.00
Student 25-30	$ 71.00	Spouse 25-30	$ 251.00
Student 31-40	$119.00	Spouse 31-40	$ 397.00
Student 41 & over	$250.00	Spouse 41 & over	$ 841.00
		Each Child	$ 116.00

PREMIUM CALCULATION

TOTAL MONTHLY PREMIUM $ _____
(ADD STUDENT/SPOUSE/CHILD RATE)

Number of Months X _____

PREMIUM NOW DUE $ _____
(MONTHLY PREMIUM TIMES # MONTHS COVERAGE)

METHOD OF PAYMENT[ ] CHECK [ ] MONEY ORDER Make payable to Student Insurance [ ] 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. 600 CORPORATE DRIVE #101 FORT LAUDERDALE FL 33334

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

PLEASE FAX INSURANCE RECEIPT TO:

NAME:_____ FAX NUMBER_____