VALENCIA ENTERPRISES

ACSA IFS INTERNATIONAL IEP STUDENT INSURANCE ENROLLMENT FORM

Underwritten by United HealthCare Insurance Company 2009 200476 4

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

STUDENT Last Name: Home Country:

First Name: Middle Initial:

STUDENT I.D. # VISA TYPE: : [ ] F1 [ ] J1 [ ] OTHER _____

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

Mailing Address:

City: State: Zip

Phone # ( ) EMAIL ADDRESS:

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

CHILD 3 Last Name _____ First Name _____

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

EFFECTIVE DATE REQUESTED : Month_____ Day _____ Year _____ COVERAGE FOR _____ WEEKS

COVERAGE CANNOT EXTEND BEYOND 10/31/2010

RATES - WEEKLY RATE WITH A MINIMUM PURCHASE OF 3 WEEKS COVERAGE REQUIRED

STUDENT

Student age 23 & under	☐ $15.00
Student Age 24 to 30	☐ $19.00
Student Age 31 & over	☐ $35.00

DEPENDENT

Spouse	☐ $60.00
Each Child	☐ $23.00
All Children	☐ $48.00

TOTAL WEEKLY PREMIUM $_____

X NUMBER OF WEEKS _____

TOTAL PREMIUM NOW DUE $_____

METHOD OF PAYMENT: [ ] CHECK [ ] MONEY ORDER Make payable to Student Insurance [ ] Credit Card (complete below)

PREMIUM NOW DUE $_____

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 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