BENNINGTON COLLEGE 2018-2019 IFS PRIME PLUS PLAN

INTERNATIONAL STUDENT HEALTH INSURANCE ENROLLMENT FORM

Student Resources (SPC) a United HealthCare Insurance Group * Policy Number 2018-202917-91

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

Student's Last Name:

First Name: Middle Initial:

Student I.D. # Home Country:

Date of Birth (Month/Day/Year): _____/_____/_____ [ ] Male [ ] Female VISA TYPE: [ ] F1 [ ] M1 [ ] J1

U.S.A Address:

City: State: Zip:

Phone #: ( ) Email Address:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only when the student first applies for insurance or within 31 days of birth, marriage or arrival in the USA.

SPOUSE Last Name: _____ First Name: _____

Date of Birth: (Month/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female VISA Type: _____

CHILD 1 Last Name: _____ First Name: _____

Date of Birth: (Month/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female VISA Type: _____

CHILD 2 Last Name: _____ First Name: _____

Date of Birth: (Month/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female VISA Type: _____

PREMIUM

STUDENT/SCHOLAR	New and Continuing Students (365 Days)	December 2018 Graduates (139 Days)	June 2019 Graduates (304 Days)
01 Student age 24 & under	☐$ 1,097.00	☐$ 417.00	☐$ 909.00
02 Student age 25 to 30	☐$ 1,566.00	☐$ 600.00	☐$ 1,306.00
03 Student age 31 to 40	☐$ 3,414.00	☐$ 1,302.00	☐$ 2,837.00
04 Student age 41 & older	☐$ 7,070.00	☐$ 2,693.00	☐$ 5,870.00
DEPENDENTS			
05 Spouse	☐$ 6,989.00	☐$ 2,664.00	☐$ 5,806.00
06 Each Child	☐$ 3,871.00	☐$ 1,475.00	☐$ 3,215.00

COVERAGE DATES

☐ New & Continuing Students - 365 Days	☐ December 2018 Graduates – 139 Days	☐ June 2019 Graduates - 304 Days
8/15/2018 to 8/14/2019	8/15/2018 to 12/31/2018	8/15/2018 to 6/14/2019

METHOD OF PAYMENT: **[ ] CHECK [ ] MONEY ORDER** ***(Make payable to Insurance for Students, INC.)***
[ ] CREDIT/DEBIT CARD - ***(Please complete below)***

Please include a processing fee per enrollee for credit & debit card payments ONLY

☐ $ 30 (365 Day Coverage) ☐ $ 15 (139 Day Coverage) ☐ $ 25 (304 Day Coverage)

PREMIUM NOW DUE $ _____

Please bill my card for the insurance premium shown above and include the appropriate processing fee:

Credit Card Authorization: [ ] MasterCard [ ] Discover [ ] American Express [ ] Visa

Cardholder Name: (Last/First) _____

Card Number:__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|Expiration Date: (Month/Year)__|__Sec. Code:_____

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/scholar at Bennington College to purchase this insurance.

Student's Signature: Date:

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS, INC. 1690 S. CONGRESS AVE, SUITE 101 DELRAY BEACH FL 33445

PHONE: 800-356-1235 FAX 954-772-0872

ONLINE www.insuranceforstudents.com/bennington

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