HILLSBOROUGH COMMUNITY COLLEGE

2022 – 2023 INTERNATIONAL STUDENT HEALTH INSURANCE PROGRAM

Underwritten by CRUM & FORSTER **Policy # 22-SGP021236**

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

STUDENT: Last Name:

First Name: Middle Initial:

Student I.D #: Student Visa Type: _____

Date of Birth: Month _____ Day _____ Year_____ [ ] Male [ ] Female

Mailing Address:

City: State: Zip:

Phone # ( ) Home Country: _____

EMAIL ADDRESS:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students 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) _____/_____/_____ Visa Type: Gender [ ] Male [ ] Female

CHILD 1 Last Name _____First Name _____

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

CHILD 2 Last Name _____First Name _____

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

PREMIUM - PLEASE CHECK APPROPRIATE BOX

PREMIUM

STUDENT	New Students Annual	New Students Fall	Continuing Students Annual	Continuing Students Fall	Spring/Summer	Summer
Student	☐ $1,513.00	☐ $ 615.00	☐ $1,457.00	☐ $ 559.00	☐ $ 898.00	☐ $ 419.00
DEPENDENTS						
Spouse	☐ $9,290.00	☐ $ 3,775.00	☐ $8,947.00	☐ $3,432.00	☐ $5,515.00	☐ $ 2,574.00
Each Child	☐ $3,696.00	☐ $ 1,502.00	☐ $3,559.00	☐ $1,365.00	☐ $2,194.00	☐ $1,024.00

EFFECTIVE/EXPIRATION PERIODS

☐ **NEW STUDENT ANNUAL** 7/31/2022 TO 8/13/2023
☐ **CONTINUING STUDENT ANNUAL** 8/14/2022 TO 8/13/2023
☐ **SPRING/SUMMER** 1/1/2023 TO 8/13/2023
☐ **NEW STUDENT FALL** 7/31/2022 TO 12/31/2022
☐ **CONTINUING STUDENT FALL** 8/14/2022 TO 12/31/2022
☐ **SUMMER** 5/1/2023 TO 8/13/2023

PREMIUM NOW DUE $ _____

(Add Student/Spouse/Child Rate)

Please Sign and complete payment information on Page 2

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** or EMAILED to **info@insuranceforstudents.com**

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TOTAL PREMIUM NOW DUE $_____

METHOD OF PAYMENT:

[ ] CHECK Make payable to Insurance for Students

[ ] MONEY ORDER Make payable to Insurance for Students

[ ] Credit Card Please include a processing fee per enrollee for credit & debit card payments ONLY – (complete below)

☐ $45 Per Student Annual ☐ $18 Per Student Fall ☐ $27 Per Enrollee Spring/Summer ☐$12 Per Enrollee Summer ☐ 3% Per Dependent

Credit Card Authorization – Please bill my card for my insurance premium plus processing fee $_____

[ ] MasterCard [ ] Discover [ ] American Express [ ] Visa

Cardholder Name (Last/First) _____

Cardholder Number: | | | | | | | | | | | | | | | | |

Expiration Date (month/year)_____|_____Security Code ___/___/___

NOTICE TO STUDENT: I hereby apply to be a Plan Participant of the International Benefit Trust established in the Cayman Islands (the "trust") and to participate in the insurance coverage extended by GBG (the "insurers") to Plan Participants under the trust (the "coverage"). I understand that the coverage is not a general health insurance product but is intended for use in the event of a sudden and unexpected event while traveling outside my Home Country. I understand that the coverage extended to me will terminate upon my return to my Home Country unless I qualify for a benefit period or Home Country coverage. I understand that I may obtain full details of the coverage by requesting a copy of the master policy from the plan manager. I understand that the liability of the insurers as underwriters of the coverage is as provided in the master policy.

By acceptance of coverage and/or submission of any claim for benefits, the Plan Participant ratifies the authority of the signer to so act and bind the Plan Participant.

The Plan Participant undertakes to make all premium payments as they fall due in respect of the coverage extended to them. The trustee shall not be responsible for the administration of such payments.

If the Plan Participant fails to make any premium payment due in respect of the coverage extended to them, subject to the discretion of the insurance company, such coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information validity of all representations and warranties provided to the trustee in connection with its participation in the plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this subscription agreement,(together "representations & warranties"). The Plan Participant acknowledges that certain of such information will be relied upon by the insurers as providers of the coverage and that any inaccuracy therein may result in the invalidity of such coverage as it relates to the Plan Participant, the loss of coverage and all monies paid in relation thereto. The Plan Participant hereby undertakes to inform the trustee of any change to any of matter that forms the subject of any of the representation & warranties. The Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any representation & warranty or failure to advise the trustee of any change in any matter that forms the subject of any of the representation & warranties. The Plan Participant agrees that the trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the Plan Participant and the Plan Participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees} occasioned by the trustee acting in accordance with any such instruction.

Payments under the terms of the coverage shall be paid by the insurers to the Plan Participant or directly to a provider if assignment of benefits has been authorized. The trustee shall not be responsible for the administration of such payments.

PREMIUM WILL NOT BE REFUNDED EXCEPT FOR INELIGIBILITY OR ENTRANCE INTO THE ARMED FORCES

I confirm that I have satisfied myself that the coverage is appropriate for me and that I meet the eligibility criteria. I agree to participate in the International Benefit Trust, and understand that participation in the trust is a prerequisite to procuring the insurance coverage.

Student's Signature:_____ **Date:** _____

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