IFS ROSE PLAN Injury & Sickness Insurance Program

Enrollment Form for International Scholars (J-1 Visa Only)

Underwritten by Crum & Forster **22-IFS-046-HC**

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

SCHOLAR: Last Name:

First Name: Middle Initial:

Student I.D #/ Passport #: [ ] J1 Scholar Visa Type [ ] Other Visa Type _____

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

Mailing Address:

City: State: Zip:

Phone # ( ) EMAIL ADDRESS:

NAME OF SCHOOL OR ORGANIZATION:

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 - Rates are Valid for coverage EFFECTIVE After 7/1/2022 COVERAGE CANNOT EXTEND BEYOND 9/30/2023

ANNUAL RATES **Effective Date Requested: Month_____ Day _____ Year_____**

SCHOLAR		DEPENDENT RATES	
Scholar age 16-24	$ 723.00	Dependent Spouse:	$ 4,267.00
Scholar age 25-49	$ 924.00	Dependent Child:	$ 1,643.00
Scholar age 50-64	$ 1,931.00		

TOTAL PREMIUM $ _____

(Add Scholar/Spouse/Child Rate)

DAILY RATES *(30 Days minimum)*

Coverage Dates: Effective Date Requested: Month _____Day_____ Year_____

Termination Date: Month _____Day_____ Year_____

SCHOLAR		DEPENDENT RATES	
Scholar age 16-24	$ 1.98	Dependent Spouse	$ 11.69
Scholar age 25-49	$ 2.53	Dependent Child	$ 4.50
Scholar age 50-64	$ 5.29		

Daily Premium: $_____

(Add Scholar/Spouse/Child Rate)

Number of Days X _____

PREMIUM NOW DUE $ _____

(DAILY PREMIUM TIMES # DAYS COVERAGE)

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 4% processing fee per enrollee for credit & debit card payments ONLY

Credit Card Authorization – Please bill my card for my insurance premium plus 4% processing fee $_____

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

Cardholder Name (Last/First) _____

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

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

NOTICE TO Scholar: I hereby apply to be a participant of the Fairmont Specialty Trust (the "Trust") and to participate in the insurance coverage (the "Coverage") under the Trust by Crum & Forster SPC ("the Company") under which I am considered an Insured. 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. I understand that the liability of the Company as insurer of the Coverage is as provided in the Policy.

By acceptance of Coverage and/or submission of any claim for benefits, the Insured ratifies the authority of the signer to so act and bind the Insured Person.

The Insured undertakes to make all Premium payments as they fall due in respect of the Coverage extended to him or her. Neither the trust nor its administrator or insurance broker (collectively, the "Plan Administrator") shall not be responsible for the administration of such payments.

If the Insured fails to make any Premium payment due in respect of the Coverage extended to him or her, subject to the discretion of the Insurance Company, such Coverage will lapse.

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

Payments under the terms of the Coverage shall be paid by the Insurers to the Insured or directly to a provider if assignment of benefits has been authorized. The Plan Administrator 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 insurance is appropriate for me and that I meet the eligibility criteria.

Scholar's Signature: _____ **Date:** _____

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