2018-2019 Global Care Essential Plan $100 Deductible
Injury and Sickness Insurance Policy for Scholars
Underwritten by Student Resources (SPC) a United Healthcare Group Company Policy # 2018-203314-91

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

Scholar's Last Name:_____ I am a [ ]STUDENT or [ ]SCHOLAR with [ ]F1 [ ]M1 [ ]J1 [ ]OTHER ____

First Name:_____ Middle Initial:_____

Scholar I.D #:_____ Home Country:_____

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

U.S.A Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone #:( ) _____ Email Address:_____

NAME OF COLLEGE OR UNIVERSITY:

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 (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- Rates are valid for coverage EFFECTIVE After 7/1/2018 (COVERAGE CANNOT EXTEND BEYOND 9/30/2019)

COVERAGE PERIOD: Effective date (month/day/year):_____

[ ] Annual or [ ] Daily for ____ days.

ANNUAL RATES		DAILY RATES (90 DAY MIN)	
SCHOLAR RATES:		**SCHOLAR RATES:**	
Age 24 & Under	$ 557.00	Age 24 & Under	$ 1.53
Student 25-30	$ 893.00	Student 25-30	$ 2.44
Student 31-40	$ 1,964.00	Student 31-40	$ 5.38
Student 41-64	$ 4,545.00	Student 41-64	$ 12.45
DEPENDENT RATES		**DEPENDENT RATES**	
Spouse	$ 5,526.00	Spouse	$ 15.15
Each Child	$ 2,995.00	Each Child	$ 8.22

PREMIUM CALCULATION

DAILY Premium Calculation:

TOTAL DAILY PREMIUM $ _____
(ADD SCHOLAR/SPOUSE/CHILD RATE)

Number of Days: X_____

DAILY Total Premium $_____

ANNUAL Total Premium $_____
(ADD SCHOLAR/SPOUSE/CHILD RATE)

METHOD OF PAYMENT:

[ ] CHECK [ ] MONEY ORDER (Make payable to Insurance for Students, Inc.) [ ] Credit Card/Debit Card

IMPORTANT: If paying by credit/debit include a processing fee per enrollee:

☐ $24 Per Enrollee Annual ☐ $2 Per Enrollee Per 30 days

TOTAL PREMIUM NOW DUE: $_____

Please complete below if paying by credit card/debit card

Credit Card/Debit Authorization – [ ] MasterCard [ ] Discover [ ] American Express [ ] Visa Please bill my card for my insurance premium shown above

Cardholder Name: (Last/First) _____

Cardholder Number: | | | | | | | | | | | | | | | | Expiration Date (month/year):___|___ CVC:_____

NOTICE TO SCHOLAR: 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.

Scholar's Signature: Date:

FOR QUESTIONS PLEASE CONTACT: INSURANCE FOR SCHOLARS

1690 S. CONGRESS AVENUE, SUITE #101, DELRAY BEACH, FL 33445

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

WWW.INSURANCEFORSCHOLARS.COM

APPLICATIONS CAN BE SUBMITTED VIA: Email: INFO@INSURANCEFORSTUDENTS.COM OR Fax # 954-772-0872

If paying via check please mail to Insurance for Students at the address listed above