2018-2019 Global Care Essential Plan $500 Deductible
Injury and Sickness Insurance Policy for Scholars
Underwritten by Student Resources (SPC) a United Healthcare Group Company Policy # 2018-203314-93

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	$ 500.00	Age 24 & Under	$ 1.37
Student 25-30	$ 803.00	Student 25-30	$ 2.20
Student 31-40	$ 1,764.00	Student 31-40	$ 4.84
Student 41-64	$ 4,083.00	Student 41-64	$ 11.18
DEPENDENT RATES		**DEPENDENT RATES**	
Spouse	$ 4,963.00	Spouse	$ 13.60
Each Child	$ 2,690.00	Each Child	$ 7.37

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