

# INSURANCE FOR STUDENTS – PRIME PLAN ENROLLMENT FORM

## International Student Injury and Sickness Program

**Underwritten by Student Resources (SPC) a United Healthcare Group Company Policy # 2017-202918-91**

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

STUDENT/SCHOLAR Last Name:

First Name:

Middle Initial:

Student I.D #:

I am a  Student OR  Scholar with  F1  J1  OTHER \_\_\_\_\_

Date of Birth (Month/day/year):

Male  Female

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 (Mo/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#:     -     -     Gender  Male  Female

CHILD 1 Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth (Mo/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#:     -     -     Gender  Male  Female

CHILD 2 Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth (Mo/Day/Year) \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#:     -     -     Gender  Male  Female

**PREMIUM** - Rates are Valid for coverage EFFECTIVE After 7/1/2017 COVERAGE CANNOT EXTEND BEYOND 9/30/2018

**Effective date (month/day/year):**

**ANNUAL RATES**

**DAILY RATES (90 DAY MIN)**

**PREMIUM CALCULATION**

**STUDENT/SCHOLAR RATES**

Age 24 & Under     \$ 730.00  
 Student 25-30     \$ 1,138.00  
 Student 31-40     \$ 3,444.00  
 Student 41-64     \$ 5,513.00

**DEPENDENT RATES**

Spouse             \$ 5,665.00  
 Each Child       \$ 3,441.00

**STUDENT/SCHOLAR RATES**

Age 24 & Under     \$ 2.00  
 Student 25-30     \$ 3.12  
 Student 31-40     \$ 9.43  
 Student 41-64     \$ 15.11

**DEPENDENT RATES**

Spouse             \$ 15.52  
 Each Child       \$ 9.43

**TOTAL PREMIUM \$ \_\_\_\_\_**  
 (ADD STUDENT/SPOUSE/CHILD RATE)

Please include a processing fee per enrollee for credit & debit card payments ONLY      \$24 Per Enrollee Annual or  
 \$2 Per Enrollee Per 30 days

**METHOD OF PAYMENT:**

CHECK      MONEY ORDER Make payable to Insurance for Students      Credit Card (complete below)

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

Cardholder Name (Last/First) \_\_\_\_\_

Cardholder Number: | | | | | | | | | | | | | | | |     Expiration Date (mo/year)     |     .

**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 enrolled or scholar to purchase this insurance.

Student's Signature:

Date:

**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