IFS Sunflower Plan Injury & Sickness Insurance Program

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

Underwritten by AXIS Specialty Europe SE **21-IFS-041**

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 7/1/2021 COVERAGE CANNOT EXTEND BEYOND 9/30/2022

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

SCHOLAR		DEPENDENT RATES	
Scholar age 16-24	$ 639.00	Dependent Spouse:	$ 3,804.00
Scholar age 25-49	$ 822.00	Dependent Child:	$ 1,464.00
Scholar age 50-64	$ 1,723.00		

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	$ 1.75	Dependent Spouse	$ 10.42
Scholar age 25-49	$ 2.25	Dependent Child	$ 4.01
Scholar age 50-64	$ 4.72		

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

TOTAL PREMIUM NOW DUE: $_____

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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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

☐ $24 Per Enrollee Annual or ☐ $2 Per Enrollee Per 30 days (complete below)

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: I I I I I I I I I I I I I I I I

Expiration Date (month/year)_____I_____Security Code ___/___/___

NOTICE TO SCHOLAR: I hereby apply to be a Plan Participant of the Fairmont Specialty Trust (the "Trust") and to participate in the insurance coverage extended by certain underwriters at Lloyd's (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 Administrator. I understand that the liability of the Insurer as underwriter 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. 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, subject to the discretion of the Insurer, such Coverage will lapse.

The Plan Participant hereby confirms the accuracy of all information and 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 Insurer as provider 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 matter that forms the subject of any of the Representations & 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 Representations & Warranties or failure to advise the Trustee of any change in any matter that forms the subject of any of the Representations & 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.

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 Fairmont Specialty Trust and understand that participation in the trust is a prerequisite to procuring the insurance coverage.

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

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