2017-2018 INTERNATIONAL STUDENT SERVICES INC - BASIC PLAN

Catlin Insurance Company **Policy Number 0925-2653**

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

STUDENT Last Name:

First Name: Middle Initial:

Student I.D #: OR Social Security #: - -

Date of Birth (Month/day/year): [ ] Male [ ] Female

Mailing Address:

City: State: Zip:

Phone # ( ) EMAIL ADDRESS:

I am a [ ] Student OR [ ] Scholar with [ ] F1 [ ] J1 [ ] OTHER _____ Home Country:

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

CHILD 3 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

PREMIUM: 90 DAY ENROLLMENT IS MINIMUM REQUIRED Rates are Valid for coverage EFFECTIVE AFTER 8/1/2017

COVERAGE CANNOT EXTEND BEYOND 10/31/2018

Effective date (month/day/year): **Number of Months covered:**

DAILY RATES – 90 DAY MINIMUM ENROLLMENT

INTERNATIONAL STUDENT RATES		INTERNATIONAL DEPENDENT RATES	
Student (Ages 64 & under)	$ 1.68	Spouse (Ages 64 & under)	$ 4.20
		Each Child	$ 2.13
		Children (3 or more)	$ 6.37

PREMIUM CALCULATION

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

Number of DAYS **X _____**

PREMIUM NOW DUE **$ _____**
(DAILY PREMIUM TIMES # DAYS COVERAGE)

METHOD OF PAYMENT:

[ ] CHECK **[ ] MONEY ORDER Make payable to Student Insurance** **[ ] 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 at a college or university to purchase this insurance.

Student's Signature: Date:

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS

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 FAXED IF PAYING BY CREDIT CARD