2018-2019 ISSI- ELITE PLUS PLAN
INTERNATIONAL SCHOLAR INJURY & SICKNESS INSURANCE PROGRAM

Catlin Insurance Company **Policy Number 0925-2655**

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

SCHOLAR Last Name:

First Name: Middle Initial:

Scholar I.D #:

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) _____/_____/_____ Gender [ ] Male [ ] Female Visa Type _____

CHILD 1 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female Visa Type _____

CHILD 2 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female Visa Type _____

CHILD 3 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ Gender [ ] Male [ ] Female Visa Type: _____

PREMIUM: 90 DAYS ENROLLMENT IS MINIMUM REQUIRED Rates are Valid for coverage EFFECTIVE AFTER 8/1/2018 COVERAGE CANNOT EXTEND BEYOND 10/31/2019 Coverage cannot be purchased for more than 365 days in one policy year,

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

DAILY RATES – 90 DAYS MINIMUM REQUIRED

SCHOLAR RATES		**DEPENDENT RATES**	
Student/Scholar (Ages 64 & under)	$ 5.33	Spouse (ages 64 & under)	$ 13.32
		Each Child	$ 6.68

PREMIUM CALCULATION

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

Number of days **X _____**

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

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: | | | | | | | | | | | | | | | | Exp. Date (mo/yr) | | SEC Code: _____

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 in classes or a 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