2018-2019 ISSI- VALUE PLAN
INTERNATIONAL SCHOLAR INJURY & SICKNESS PROGRAM

Catlin Insurance Company **Policy Number 0925-2654**

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

SCHOLAR Last Name:

First Name: Middle Initial:

Student 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 ENROLLMENT

SCHOLAR RATES		**DEPENDENT RATES**	
Student/Scholar (Ages 64 & under)	$ 3.80	Spouse (ages 64 & under)	$ 9.47
		Each Child	$ 4.77

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