UNIVERSITY OF WEST FLORIDA

2018-2019 INTERNATIONAL STUDENT HEALTH INSURANCE PROGRAM

STUDENT RESOURCES (SPC) Ltd. A UnitedHealth Group Company Policy 2018-203157-91

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

Student's Last Name:_____ I am a [ ]STUDENT with [ ]F1 [ ]M1 [ ]J1 [ ]OTHER ____

First Name:_____ Middle Initial:_____

Student I.D #:_____ Home Country:_____

Date of Birth (Month/Day/Year):_____ [ ]Male [ ]Female

U.S.A Mailing Address:_____

City:_____ State:_____ Zip:_____

Phone #:(_____) _____ Email Address:_____

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 (month/day/year):_____/_____/_____ Gender [ ] Male [ ] Female Visa Type: [ ]F1 [ ]M1 [ ]J1 Other:____

CHILD 1 Last Name _____ First Name:_____

Date of Birth (month/day/year):_____/_____/_____ Gender [ ] Male [ ] Female Visa Type: [ ]F1 [ ]M1 [ ]J1 Other:____

CHILD 2 Last Name _____ First Name:_____

Date of Birth (month/day/year):_____/_____/_____ Gender [ ] Male [ ] Female Visa Type: [ ]F1 [ ]M1 [ ]J1 Other:____

PREMIUM- (Please check appropriate box)

	ANNUAL: 8/15/18 to 8/14/19	**FALL:** 8/15/18 to 12/31/18	**SPRING/SUMMER:** 1/1/19 to 8/14/19	**SUMMER:** 5/6/19 to 8/14/19
Student	☐ $ 1,498.00	☐ $ 578.00	☐ $ 920.00	☐ $ 408.00
DEPENDENT(S):				
Spouse	☐ $ 7,356.00	☐ $ 2,843.00	☐ $ 4,513.00	☐ $ 2,005.00
Each Child	☐ $ 3,920.00	☐ $ 1,515.00	☐ $ 2,405.00	☐ $ 1,068.00

METHOD OF PAYMENT:

[ ] CHECK **[ ] MONEY ORDER (Make payable to Insurance for Students, Inc.)** **[ ] Credit Card/Debit Card**

IMPORTANT: If paying by credit/debit include a processing fee per enrollee:

☐ **$35 (Annual)** ☐ **$15 (Fall)** ☐ **$25 (Spring/Summer)** ☐ **$10 (Summer)**

TOTAL PREMIUM NOW DUE: $_____

Please complete below if paying by credit card/debit card

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

Cardholder Name: (Last/First) _____

Cardholder Number:_____Expiration Date (month/year):_____CVC:_____

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 University of West Florida 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

www.insuranceforstudents.com/uwf

APPLICATIONS CAN BE MAILED TO ADDRESS ABOVE OR IF PAYING BY CREDIT CARD CAN BE FAXED TO (954) 772-0872