2009 2010 INTERNATIONAL COMMUNITY SERVICE – PLAN A

United HealthCare Insurance Company **New York residents only** **2009 201293-91**

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

STUDENT/SCHOLAR Last Name:

First Name: Middle Initial:

Social Security # - - OR 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

[ ] New Applicant OR [ ] Renewal MY ICS Coordinator Identification Number (CID) is |__|__|__|__|__| (for ICS coordinator only)

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 3 MONTH ENROLLMENT IS MINIMUM REQUIRED

Rates are Valid for coverage EFFECTIVE AFTER 8/1/2009 COVERAGE CANNOT EXTEND BEYOND 10/31/2010

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

MONTHLY RATES – 3 MONTH MININUM ENROLLMENT

STUDENT/SCHOLAR RATES		DEPENDENT RATES	
Age 30 & under	$ 68.00	Spouse 30 & under	$ 285.00
Student 31-40	$ 85.00	Spouse 31-40	$ 342.00
Student 41 & over	$103.00	Spouse 41 & over	$ 411.00
		Each Child	$ 123.00

PREMIUM CALCULATION

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

Number of Months X _____

PREMIUM NOW DUE $ _____
(MONTHLY PREMIUM TIMES # MONTHS 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 or scholar to purchase this insurance

Student's Signature Date

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS, INC. 600 CORPORATE DRIVE #101 FORT LAUDERDALE FL 33334

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