Study USA-HealthCare™ Enrollment Form

Official Use Only: 06/09
Conf.#
PC#
Eff Date: ___/___/___
Date Rec'd: ___/___/___

Please read the Study USA-HealthCare **Instructions** before completing this enrollment.

1. Insured's Information (Please Print Clearly)

Last Name ________________________________

First Name ________________________________

Mailing Address ________________________________

City ________________________________

State/Province, Zip/Postal Code ________________________________

Country ________________________________

Phone ________________________________

Email Address ________________________________

Passport Number ________________________________

Country Issuing Passport ________________________________

Visa Type ________________________________

☐ I am an international student currently registered to study in the U.S.

☐ I am a U.S. registered student studying outside the U.S.

Name of school, college or university ________________________________

Your school is located in which state ________________________________

2. Enrollment Type

☐ First Time Enrollment

☐ Dependent Enrollment Only

Confirmation Number ____________________

☐ Renewal for Self/Dependents

Confirmation Number ____________________

Plan Requested: ☐ Plan A ☐ Plan B

Months of Coverage (maximum 12 months): ___________

Requested Effective Date: (month/day/year) _____/____/_____

3. Payment

Choose one method. (See instructions below for details.)

☐ Enroll by Mail
Payment: ☐ check ☐ credit card

☐ Enroll by Fax:
Pay with credit card only (**DO NOT** mail originals.)

Credit Card Type ☐ Visa ☐ MasterCard ☐ Discover

Card # ______________________________ Exp. ____ / ____

Card Holder Name ______________________________

Billing Address ______________________________

City, State, Zip ______________________________

Signature ______________________________ Date ____ / ____

4. Rate Calculation

Name - Complete the form below for yourself and any dependents you are enrolling.

Name		Arrival Date in Country of Study (month/day/year)	Monthly Premium	Total Monthly Premium	# of Months (max.12)	Total Payment
Insured Name	_________________________	____/____/____	$_______	= $_______	x____	=_______
Insured Date of Birth (month/day/year) ____/____/____						
Spouse Name	_________________________	____/____/____	$_______	= $_______	x____	=_______
Spouse Date of Birth (month/day/year) ____/____/____						
Dependent Name	_________________________	____/____/____	$_______	= $_______	x____	=_______
Dependent Date of Birth (month/day/year) ____/____/____						

Subtotal =_______

Administration Fee + $ 5.00

OPTIONAL: Include your fax number: (_______) _______ - __________ for a rushed fax copy of Confirmation. Add $10.00 +________

I hereby enroll in Study USA-HealthCare. All claims will be fully investigated. Premiums received by the Program Marketer / Insurance Company will be considered fully earned and non-refundable. Coverage under this program terminates if a covered Person enters military service and a pro-rata refund will be made from the date a written request is received. Otherwise, no refunds will be made.

Total $________

Signature of Insured or Proxy ____ Date _________

Instructions

Print this enrollment form and complete the hard copy (items 1-4) for you, your spouse, and your children (under age 18). Incomplete forms will not be processed and will be returned.

You may pay by check, money order, MasterCard, Visa or Discover. Make check or money order for full premium payable to Travel Insurance Services. All payments must be in U.S. dollars drawn on a U.S. bank. Do not send cash.

Mail payment and completed enrollment form to [illegible]. Alternately, you may fax your enrollment to [illegible]. If faxing, please **DO NOT** mail the original enrollment form as this causes unnecessary duplication.

After you mail or fax your enrollment, Proof of Insurance will be sent by mail to your U.S. address on the enrollment form unless otherwise instructed. Correctly completed enrollments are processed and Confirmations of Insurance are normally mailed within 1-3 business days after receipt.

Monthly Premiums

Age	Plan A	Plan B
0 - 24	$38	$40
25 - 29	$55	$58
30 - 34	$70	$74
35 - 39	$99	$104
40 - 44	$125	$131
45 -49	$135	$142
50 - 54	$250	$263
55 - 65	$300	$315
Spouse	$450	$473
Child	$90	$95

Premium Payment

You can enroll for up to twelve months at one time. You must pay premium in full for your enrollment period.

Refund of Premium

Premiums received by the Program Administrator will be considered fully earned and non-refundable. Coverage under this Program terminates if a Covered Person enters military service and a pro-rata refund will be made from the date written request is received. Otherwise, no refunds will be made.