Study USA-HealthCare™ Enrollment Form

Official Use Only: 06109
Conf.#
PC# 132807
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 _____
State your school is located _____

2. Enrollment Type

☐ First Time Enrollment
☐ For Myself ☐ For Myself and Dependents

☐ 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.	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: Fax Your Completed Form To USA 01-610-537-9828

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 Travel Insurance Services, Broker 132807, 2950 Camino Diablo, Suite 300, Walnut Creek, CA 94597-3991. Alternately, you may fax your enrollment to 01-610 537-9828. 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 - 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.