INTERNATIONAL STUDENT INSURANCE

ENROLLMENT FORM

STUDENT INSURANCE Since 1950®

How to Enroll:

1. One application per student only. **Application must be completed in black or blue ink only! NO PENCIL**
2. Make check or money order payable to: **STUDENT INSURANCE** and mail to:
   11661 San Vicente Blvd., Suite 200
   Los Angeles, CA 90049
3. Enclose payment with application. **DO NOT** mail cash. Visa or MasterCard Accepted.
4. Retain the brochure for your records. Individual policies will **not** be issued.

Please complete and print clearly.

First Name | MI | Last Name

Date of Birth (M M D D Y Y) | Sex | S.S. # / I.D. # (***required to process application***) | Alien Visa Type

Email Address

U.S. Only Mailing Address | Apt#

City | State | Zip Code

U.S. Phone Number | Name of Home Country

PREMIUM RATES

I wish to enroll for insurance under the terms of the **Master Policy #2007-200473-4** as follows (CHECK APPROPRIATE BOX):

Premium:	☐ Annual Premium 8/1/07-8/1/08 Cannot be purchased after 9/15/07	☐ 1st Semi-Annual 8/1/07-2/1/08 Cannot be purchased after 9/15/07	☐ 2nd Semi-Annual 2/1/08-8/1/08 Cannot be purchased after 3/15/08	☐ Summer 6/1/08-8/1/08 Cannot be purchased after 7/1/08	☐ Monthly Option Begin M M **0 1** Y Y for _____ month (s)
Student	$720.00	$360.00	$360.00	$120.00	$65.00 a month (**4 month MAX**)

In order to insure the spouse and/or child or children, the student must be insured. Dependent spouse and/or child or children must be insured with the same effective date as the student or within 31 days of arrival if after the student. Newborn child must be enrolled within 31 days of birth.

Spouse Premium: $153/Month **Dependent Child Premium: $49/Month** **Dependent Children (3 or more): $146/Month**

☐ STUDENT ONLY

☐ STUDENT AND SPOUSE*

☐ STUDENT, SPOUSE*, AND CHILDREN*

Name of Dependents to be Insured:	Date of Birth:	Sex:
Spouse _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____
Child _____	_____	_____

TOTAL PREMIUM ENCLOSED

$ _____ . _____

Visa / MasterCard "Only" - - -

Expiration Date -

Cardholder's Name

Signature: **X** _____

The undersigned understands and agrees that:

1. This is specialized coverage and is not a general health insurance policy. It is intended to provide benefits for medical expenses for treatment or a sickness or injury incurred while insured under the policy.
2. The policy does not provide benefits for sickness or injuries, which existed prior to the effective date of my insurance, and I further agree to the exclusion of coverage for pre-existing conditions as defined within the policy.

I certify that as the applicant named above, I am engaged in full time educational activities through the school indicated and that I am a non-resident alien and not a permanent resident of the Host Country. I understand that an Insured Person or Insured Dependent whose coverage under the policy lapses shall be subject to all policy provisions and exclusions as of any subsequent effective date. I declare that the information I have provided is accurate and complete. If there is a change in the information I have provided on this application during the 2007-2008 academic year, I will inform the United Healthcare Insurance Company or STUDENT INSURANCE immediately.

Signature of Applicant: _____ Date: _____