MIAMI DADE COLLEGE

2015 2016 INTERNATIONAL STUDENT HEALTH INSURANCE PROGRAM

CAMPUS

[ ] Wolfson [ ] North [ ] Medical [ ] Homestead [ ] Interamerican [ ] Kendall

United Health Care Insurance Group **Policy Number 2015-533-4**

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

STUDENT Last Name:

First Name: Middle Initial:

Student I.D. # HOME COUNTRY:

Date of Birth (Month/day/year): [ ] Male [ ] Female

Mailing Address:

City: State: Zip:

Phone # ( ) EMAIL ADDRESS:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only when the student first applies for insurance or within 31 days of birth, marriage or arrival in the USA.

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

PREMIUM

	FALL	SPRING	FALL & SPRING
STUDENT	☐ $ 528.00	☐ $ 491.00	☐ $ 1,019.00
DEPENDENT(S):			
Spouse	☐ $1,853.00	☐ $1,721.00	☐ $3,574.00
Each Child	☐ $ 698.00	☐ $ 648.00	☐ $1,346.00
All Children (2 or more)	☐ $ 912.00	☐ $ 845.00	☐ $ 1,757.00

COVERAGE DATES

☐ FALL	☐ SPRING	☐ FALL & SPRING
8/15/2015 to 12/31/2015	1/1/2016 to 5/8/2016	8/15/2015 to 5/8/2016

METHOD OF PAYMENT

[ ] CHECK **[ ] MONEY ORDER Make payable to Insurance for Students** **[ ] Credit Card (complete below)**

Please include a processing fee per enrollee for credit & debit card payments ONLY

☐ $ 20 (Fall coverage) **☐ $ 15 (Spring coverage)** **☐ $ 30 (Fall & Spring coverage)**

PREMIUM NOW DUE $ _____

Please bill my card for my insurance premium shown above and include the appropriate processing fee

Credit Card Authorization: [ ] MasterCard [ ] Discover [ ] American Express [ ] Visa

Cardholder Name (Last/First) _____

Card Number: _____ Expiration Date (mo/year)_____ Sec. Code_____

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 at Miami Dade College to purchase this insurance.

Student's Signature: Date:

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS, INC. 5295 TOWN CENTER ROAD, SUITE 101 BOCA RATON FL 33486

PHONE 800-356-1235 FAX 954-772-0872 ONLINE www.insuranceforstudents.com/mdc

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