BROWARD COLLEGE INTERNATIONAL** VANTAGE PLAN

UNITED HEALTHCARE Insurance Company Enrollment Form Policy 2010-201293-92

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

STUDENT/SCHOLAR Last Name:

First Name: Middle Initial:

Student I.D. # **CAMPUS:**

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

Mailing Address:

City: State: Zip:

Phone # ( ) EMAIL ADDRESS: HOME COUNTRY:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan.

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

STUDENT	Annual (A-)	Fall (5-)
01 Student 24 & under	☐ $ 624.00	☐$ 260.00
02 Student age 25 to 30	☐ $ 888.00	☐$ 370.00
03 Student age 31 to 40	☐ $ 1,284.00	☐$ 535.00
04 Student age 41 & Over	☐ $ 2,472.00	☐$ 1,030.00

DEPENDENTS	Annual (A-)	Fall (5-)
06 Spouse 24 & under	☐ $ 2,532.00	☐$ 1,055.00
07 Spouse age 25 to 30	☐ $ 3,636.00	☐$ 1,515.00
08 Spouse age 31 to 40	☐ $ 5,088.00	☐$ 2,120.00
09 Spouse 41 & over	☐ $ 9,852.00	☐$ 4,105.00
11 Each Child	☐ $ 1,320.00	☐$ 550.00

EFFECTIVE/EXPIRATION PERIODS

☐**ANNUAL** 8/23/2010 TO 8/22/2011 ☐ **FALL** 8/23/2010 TO 01/22/2011

PREMIUM NOW DUE $ _____

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) _____ I _____.

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/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