International plus Student and Scholar
2014–2015 Medical Insurance Plan

Enroll by email by sending form to to customerservice@hginsurance.com, by fax: 937.748.5208, or by mail

Monthly Premium Rates

The rates below are valid for enrollment with an effective date on or before July 28, 2015.

	Deductible	$150[1]		$250[2]	
	Medical Maximum	$250,000	$500,000	$250,000	$500,000
Age	Under 19	$90	$102	$85	$96
	19-23	$102	$116	$96	$109
	24-29	$129	$147	$122	$138
	30-35	$234	$266	$221	$251
	36-49	$524	$596	$495	$561
	50-64	$675	$768	$638	$723

[1] $150 Deductible is per person Per Occurrence of Coverage. Deductible is reduced to $50 if initial medical treatment or referral is provided by the college or university's Student Health Center.

[2] $250 Deductible is per person Per Occurrence of Coverage. Deductible is reduced to $100 if initial medical treatment or referral is provided by the college or university's Student Health Center.

The Underwriter

The Group Plan is underwritten by Certain Underwriters at Lloyd's, London. As the largest insurance entity in the world, Lloyd's has earned an A (Excellent) rating from AM Best and an A+ (Strong) Rating from Standard and Poor's.

Plan Arranged By

THE HARBOUR GROUP

A NAFSA Global Partner

The Harbour Group of Ohio, LLC
93 Edgebrook Drive
P.O. Box 998
Springboro, Ohio 45066 USA

Telephone: 937.748.5200
Toll-free: 800.252.8160
Fax: 937.748.5208

Email: info@hginsurance.com
www.hginsurance.com

Administration

Policy and claims administration provided by Seven Corners, Inc.

International plus Student and Scholar 2014–2015 Medical Insurance Plan Enrollment Form

This enrollment form cannot be submitted online at this time. Please submit enrollment form by email, fax or mail.

Enroll by email by sending form to to customerservice@hginsurance.com, by fax: 937.748.5208, or by mail

Please print, answer all questions and sign below.

Last Name *(Please print one letter per block.)*

Date of Birth (Month / Day / Year)

First Name

☐ Male ☐ Female

U.S.A. Street Address _____

City _____ State _____ Zip/Postal Code _____

Telephone ( ) _____ E-mail _____

Name of School/City you will be attending _____

Type of visa held: ☐ F-1 ☐ J-1 ☐ M-1 ☐ Other _____ Home Country _____

Eligibility *(Check one):* ☐ Undergraduate ☐ Graduate ☐ Scholar ☐ Other (Describe) _____

I Wish To Enroll For Insurance Under The Terms Of The Policy As Follows:

REQUIREMENT: You must include a copy of your **I-20 or DS-2019** with the enrollment form.

I want my insurance to begin on (Month / Day / Year)

Insurance will be effective on the later of: the date requested; or the date a completed enrollment form and total premium are received by The Harbour Group. (Enrollment forms sent on-line or by fax will not be effective before 12:01 a.m. on the date which is at least twenty four hours after the date the completed enrollment form and total premium are received by The Harbour Group.)

Deductible ☐ $150/$50 ☐ $250/$150

Medical Maximum ☐ $250,000 ☐ $500,000

Student or Scholar's Monthly Premium $ _____

Multiply by Number of Months Requested (Minimum 3, Maximum 12) x _____

Total Premium (amount of check, money order, or credit card payment) $ _____

Accidental Death and Dismemberment Benefits:

Participant's Beneficiary (Name)

Relationship to Participant

I hereby certify that as the student applicant named above, I am a non-resident alien and not a resident of the host country and that I am temporarily engaged in international education activities on a full time basis.

Student or Scholar's Signature *Date*

Payment:

☐ **Check** ☐ **Money Order** ☐ **VISA** ☐ **MasterCard**

Credit Card Number

Expiration Date *Security Code*

Name on Credit Card

Signature of Cardholder

Check or money order
U.S. FUNDS ONLY
should be made payable to
The Harbour Group

Send payment, enrollment and form
The Harbour Group
P.O. Box 998
Springboro, OH 45066 USA