USI AFFINITY | **Travel Insurance Services**

Underwritten by: HCC Medical Insurance Services

STUDY USA-HealthCare Application

Enrollment information: Please complete all sections. Enter Spouse and Child details only for dependents who are to be covered under this plan, if any. Questions? Call us at (800) 937-1387.

1. Participant Information

Name (First and Last)	Date of Birth (MM/DD/YYYY)	Gender	Citizenship
Student		Male	
Spouse		N/A	
Child		N/A	
Child		N/A	
Child (If more children, attach additional sheets.)		N/A	

Mailing Address: | City:

Apt./Suite/Etc.: | State/Province:

Passport Number: | Postal Code:

Home Country: | Host Country: | Primary Telephone: | Alternate Telephone:

Primary E-mail: | Alternate E-mail:

2. Student Information

Name of College/University: | State (If in US):

☐ Undergraduate ☐ Graduate ☐ Scholar

Number of Hours:

Type of Visa (I-94) *Non Us-Citizens Only:* ☐ F-1 ☐ Other

Date Classes Begin ___/___/___

Date of Departure from Home Country ___/___/___

Date of Reutrn to Home Country ___/___/___

3. Plan Selections

Please make a selection in each section.

Type of Coverage:

☐ Student Only ☐ Student & Children

☐ Student & Spouse ☐ Student & Family

Plan Level: ☐ Standard ☐ Preferred ☐ FL

Requested Effective Date: ___/___/___

US Coverage (US Citizens/Residents must select "No")

☐ Yes ☐ No

4. Payment Options

*Please select Single Payments **OR** Monthly Payments*

☐ **Single Payment** - I want to pay the full amount in one single payment

_____ (Number of Days) X _____ (Daily Rate) + $5.00 Administration Fee = 5 **Total Amount Due**

☐ **Monthly Payments*** - I want to be automatically charged every 30 days, over a 364-day period

First payment due

34 (Number of Days) X _____ (Daily Rate) + $5.00 Administration Fee = 5 **First Payment Due**

Additional payment cost:

30 (Number of Days) X _____ (Daily Rate) + $5.00 Administration Fee = 5 **Monthly Payment**

5. Payment Information

Payment Method: ☐ Check/Money Order ☐ MasterCard ☐ Visa ☐ Discover

Credit Card #: | Expiration Date: | CVV:

Name on Card: | Signature:

Address: | City:

Apt./Suite/Etc.: | State/Province:

Postal Code:

*If I have selected a monthly plan, I hereby request and authorize Travel Insurance Services to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. I hereby apply for membership in the Atlas/International Citizen Group Insurance Trust, Hamilton, Bermuda and for the insurance provided to members by Lloyd's. I understand that the insurance applied for is not a general health insurance policy, but is intended for use in the event of a sudden and unexpected event while pursuing educational endeavors outside my Home Country. I certify that I am a Full-time Student or Full-time Scholar as required by the definitions of this policy. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-notification Penalty and other restrictions and exclusions. I understand that renewal of this insurance may only be transacted online and will not be effective unless such transaction is made within the six (6) months immediately preceding my current coverage expiration date and confirmed in writing by HCC Medical Insurance Services. I understand that the information contained herein is a summary of the Master Policy and that I may obtain a complete copy of the Master Policy upon request to HCC Medical Insurance Services. I understand that Lloyd's, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand that Lloyd's operates as an approved, non-admitted insurer in all states of the United States except Illinois and Kentucky where they are admitted. As such, claims under this insurance may not be made against any state guaranty fund. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. Licensed insurance brokers and independent agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through HCC Medical Insurance Services. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.

Signature of Applicant: | Date:

Signature of Spouse: | Date:

Official Use Only:

Date Rec'd:_____ **Source:**_____ **PC#:** 133028

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STUDY USA-HealthCare Additional Information

Study USA-HealthCare Daily Rates

Student Only			
	Study USA-HealthCare Standard	Study USA-HealthCare Preferred	Study USA-HealthCare Florida
Age	Daily Rate	Daily Rate	Daily Rate
Under 25	$2.22	$2.38	$2.50
25-29	$3.24	$3.46	$3.64
30-34	$4.11	$4.39	$4.61
35-39	$5.80	$6.20	$6.51
40-44	$7.31	$7.82	$8.21
45-49	$7.92	$8.46	$8.88
50-54	$14.62	$15.63	$16.41
55-65	$17.53	$18.73	$19.67

Student & Spouse			
	Study USA-HealthCare Standard	Study USA-HealthCare Preferred	Study USA-HealthCare Florida
Age	Daily Rate	Daily Rate	Daily Rate
Under 25	$15.45	$16.51	$17.34
25-29	$19.33	$20.66	$21.69
30-34	$26.94	$28.80	$30.24
35-39	$37.57	$40.15	$42.16
40-44	$42.05	$44.95	$47.19
45-49	$47.07	$50.31	$52.82
50-54	$52.52	$56.14	$58.94
55-65	$58.60	$62.64	$65.77

Student & Children			
	Study USA-HealthCare Standard	Study USA-HealthCare Preferred	Study USA-HealthCare Florida
Age	Daily Rate	Daily Rate	Daily Rate
Under 25	$9.75	$10.43	$10.95
25-29	$10.56	$11.29	$11.85
30-34	$12.20	$13.04	$13.70
35-39	$14.10	$15.07	$15.83
40-44	$18.45	$19.72	$20.71
45-49	$24.14	$25.81	$27.10
50-54	$29.11	$31.12	$32.68
55-65	$35.11	$37.53	$39.41

Student & Family			
	Study USA-HealthCare Standard	Study USA-HealthCare Preferred	Study USA-HealthCare Florida
Age	Daily Rate	Daily Rate	Daily Rate
Under 25	$22.69	$24.25	$25.46
25-29	$26.74	$28.59	$30.02
30-34	$34.60	$36.98	$38.83
35-39	$44.76	$47.85	$50.24
40-44	$49.06	$52.44	$55.06
45-49	$53.78	$57.48	$60.36
50-54	$58.96	$63.02	$66.17
55-65	$64.64	$69.09	$72.55

Mail Completed Application and Payment To:

USI Affinity Travel Insurance Services
3070 Riverside Drive
Columbus, OH 43221

Cancellations and Refunds

Single Payment: To be eligible for a full refund, the request for cancellation must be received in writing prior to the effective date. Cancellation requests received after the effective date will be subject to the following conditions:

A) A $20 cancellation fee will apply
B) No refunds available 60 days after the effective date
C) Only members who have no claims are eligible for premium refund

Monthly Payment: To be eligible for a full refund, the request for cancellation must be received in writing prior to the effective date. If the plan is cancelled after the effective date, all future scheduled payments will be cancelled.

Extending or Renewing Coverage

After your initial purchase, you may extend your coverage up to a maximum of 364 days from the initial effective date. You may renew your coverage as long as you continue to meet the eligibility requirements. Renewal may be completed within the last 6 months of a 12-month certificate period. Deductible and coinsurance must be re-satisfied as of each renewal date. After four years of continuous coverage or any break in coverage, a new plan must be purchased. A new application is required and you must re-satisfy your deductible, coinsurance, pre-existing condition provisions, and all other benefit limits. Extensions and renewals can be made online with payment by credit card, or by calling us at (800) 937-1387.

Questions?

If you have any questions about this plan, call Travel Insurance Services at (800) 937-1387. Office hours are Monday through Friday, 8:00 AM - 5:00 PM Pacific Time. Policy information is also available on our website at http://www.travelinsure.com/susa