



STUDY USA-HealthCare Application

Date of Birth (MM/DD/YYYY) Gender Citizenship Name of CollegeUniversity: State (if in US): Mile of Birth (MM/DD/YYYY) Gender Citizenship Name of CollegeUniversity: State (if in US): State (if in US): Mile of Hours. Spouse Undergraduate Graduate Schola Number of Hours. Type of Visa (1-94) Non Us-Citizens Only F-1 Other Date of Departure Date of Return to from Home Country Date of Return to from Home Country Home Country F-1 Other Date of Departure Date of Return to from Home Country Home Country Mile of Departure Date of Return to from Home Country Student only Student & Childre Student & Spouse Student & Family Student & Family Student & Spouse Student & Family Student & Family Student & Family Plan Level: Standard Preferred Flan Level: Standard Preferred	Enrollment information: Please complete a covered under this plan, if any. Questions?					hild details o	only for de	pendent	s who are to be
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Alternate E-mail:	Uæ••][¦o4p~{ à^¦K	Postal C	Code:				1		
Please select Single Payments OR Monthly Payments Single Payment I payments or Monthly Payments I want to be automatically charged every 30 days, over a 364-day period 43 days, over a 36	Home Country: Host Country:	Primary	Telephone:		Alternate Telep	phone:	Requested Effective Date:		
## Payment Options Single Payment - I want to pay the full amount in one single payment	Primary E-mail:	Alternat	e E-mail:		1				
Monthly Payments* - I want to be automatically charged every 30 days, over a 364-day period	4. Payment Options					Please sele			_ _
First payment due 30 days, over a 364-day period \$3.0 days, over a 364-day period \$3.0 days, over a 364-day period \$5.00 Administration Fee \$1.00 fee		n one si	ngle payment	П	Monthly Pa				, ,
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5. Payment Information Payment Method: Check/Money Order MasterCard Visa Discover Credit Card #: Expiration Date: ÖXXK Name on Card: Signature: Address: City: State/Province: Postal Code: Tit 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 provide 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 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 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 to insurance provides and the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant in understand and agree th	X + \$5.00 Administration	Fee = _			Days				First Payment Due
Days		Т	otal Amount Due	Add		nent cost: + 9	S5 00 Admini	stration Fe	ee =
S. Payment Information Payment Method: Check/Money Order MasterCard Visa Discover Credit Card #: Expiration Date: ÖXXK Name on Card: Signature: Address: City: State/Province: Postal Code: Postal Code: TIT 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 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 continue 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 I toyd's cyarent soverage expiration date and confirmed in writing by 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 in suriance in 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 and signal states of the Coverage and benefits and Kentucky where they are admitted. As such, claims under				N	umber of	Daily Rate	,0.00 , (0.111111	ou au on i	Monthly Payment
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Signature of Spouse: Date:								Date:	
	Signature of Spouse:								

Source:_

Date Rec'd:_

PC#: 133028

Rev. 11/12-C



Study USA-HealthCare Daily Rates

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Student Only					
	Study USA-HealthCar^ Standard	Study USA-HealthCare Preferred	Study USA-HealthCare Florida		
Age	Daily Rate	Daily Rate	Daily Rate		
Under 25	\$2.GG	\$2.HÌ	\$2.Í €		
25-29	\$3.G	\$3.I Î	\$3.Î I		
30-34	\$I ÈF	\$4.HJ	\$4.Î F		
35-39	\$5È€	\$ÎÈG€	\$Î ĔF		
40-44	\$Ï ÈHF	\$Ï È̀G	\$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	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 resatisfy 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