INTERNATIONAL COMMUNITY SERVICE - DISCOUNT PLAN

MEGA LIFE & HEALTH INSURANCE COMPANY ENROLLMENT FORM 2006-2007

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

STUDENT/SCHOLAR Last Name:

First Name: Middle Intitial:

Social Security # - - OR School I.D. #

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

Mailing Address:

City: State: Zip

Phone # ( ) EMAIL ADDRESS:

I am a [ ] Student OR [ ] Scholar with [ ] F1 [ ] J1 [ ] OTHER _____ Home Country

[ ] New Applicant OR [ ] Renewal MY ICS Coordinator Identification Number (CID) is |_|_|_|_|_| (for ICS coordinator only)

NAME OF COLLEGE OR UNIVERSITY:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan. Coverage must be purchased at the time of primary insured's enrollment or within 30 days of birth/marriage or arrival in country

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

CHILD 3 Last Name _____ First Name _____

Date of Birth (Mo/Day/Year) _____/_____/_____ SS#: - - Gender [ ] Male [ ] Female

PREMIUM 3 MONTH ENROLLMENT IS MINIMUM REQUIRED Rates are Valid for coverage EFFECTIVE After 8/1/2006
COVERAGE CANNOT EXTEND BEYOND 10/31/2007

Effective date (month/day/year): **Number of Months covered:**

MONTHLY RATES – 3 MONTH MININUM ENROLLMENT

STUDENT/SCHOLAR RATES		DEPENDENT RATES	
Under Age 24	$ 30.00	Spouse under 24	$116.00
Student 24-30	$ 35.00	Spouse 24-30	$136.00
Student 31-40	$ 62.00	Spouse 31-40	$254.00
Student 41-50	$ 87.00	Spouse 41-50	$355.00
Student +51	$175.00	Spouse +51	$700.00
		Each Child	$ 71.00

PREMIUM CALCULATION

TOTAL MONTHLY PREMIUM $ _____
(ADD STUDENT/SPOUSE/CHILD RATE)

Number of Months X _____

PREMIUM NOW DUE $ _____
(MONTHLY PREMIUM TIMES # MONTHS COVERAGE)

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) |_____|_____.

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 enrolled or 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