2007 2008 INTERNATIONAL COMMUNITY SERVICE - PLAN A

United HealthCare Insurance Company

For coverage with an effective date of August 1, 2007 or after

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 VALID FOR COVERAGE EFFECTIVE AFTER 8/1/2007
COVERAGE CANNOT EXTEND BEYOND 10/31/2008

MONTHLY RATES*	EFFECTIVE DATE OF COVERAGE: Month Day Year for _____ months*
A STUDENT/SCHOLAR $ 73.00 B SPOUSE $293.00 C EACH CHILD $110.00 *MINIMUM OF 3 MONTHS COVERAGE REQUIRED	PREMIUM CALCULATION MONTHLY PREMIUM OF $ TIMES NUMBER OF MONTHS _____ **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) |__|__|__|__|.

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