



International Student & Scholars Insurance Plan - Enrollment Form
Underwritten by the Insurance Company of the State of Pennsylvania

Participant's Name _____

Gender: Male Female Date of Birth _____ / _____ / _____
Month/ Day / Year

Home Country Address: _____
Street City State

Postal/ Zip Code _____ Country: _____

Passport Country _____ Visa Type: F1 J1 M1 Other _____

Name of School or Institution of International Assignment _____

Participant Status: Student Faculty Scholar Other _____

Address for Correspondence: c/o Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ Email Address: _____

Beneficiary Name*: _____

*This is the person who will receive the Accidental Death & Dismemberment benefit in the event of the Participant's death.

Requested Effective Date of Coverage: _____

Requested Period of Coverage (in months): _____

Note: Insurance cannot begin prior to the date the premium and Enrollment Form are received by Gallagher Koster. This rate is valid for Coverage through **May 31, 2010**.

Calculating Your Premium - \$65 per person, per month

Select Coverage Type: Participant only Spouse/Child (per person)
(dependent coverage is only available if the student/scholar is enrolled for coverage)

Student/Scholar: _____
Name Sex Date of Birth (MM/ DD/ YYYY)

Spouse _____
Name Sex Date of Birth (MM/ DD/ YYYY)

Child _____
Name Sex Date of Birth (MM/ DD/ YYYY)

Child _____
Name Sex Date of Birth (MM/ DD/ YYYY)

Note: You must pay for at least 1 month at a time.

Premium Calculation: \$ _____ X _____ = _____

Monthly Premium Number of Months Total Premium Enclosed

I understand that if it is discovered that I do not meet the eligible requirements, that my premium will be refunded. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the insurance company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, we will ask you for written authorization to disclosed information about you. It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signature of Participant: _____ **Date:** _____

PAYMENT INSTRUCTIONS: Please include an additional \$10.00 processing fee with your enrollment.

Charge to my (check one): Visa Master Card Check or money order (International checks are not accepted)

Card Number: _____ Amount Charged: \$ _____ Expiration Date: _____

Print Name and Address of

Cardholder: _____

My signature indicates acceptance of these terms and authorizes Gallagher Koster to charge my credit card for the total premium due for the period of coverage requested. I understand that the premium is non-refundable unless written notification is received by Gallagher Koster prior to the effective date of coverage.

Signature of Cardholder: _____

Make check or money order payable to **Gallagher Koster**. Mail or Fax enrollment form along with premium payment to: Gallagher Koster, P.O. Box 845663, Boston, MA 02284-5663, Phone: 1-800-457-5599, Fax: 617-479-0860