

International Student & Scholars Plan Enrollment Form

ACE American Insurance Company

Participant's Name _____
Gender: Male Female _____
Date of Birth _____
Home Country Address _____
Postal Code/Zip Code _____ Country _____
Passport Country _____ Country of Permanent Residence _____
Visa Type: ___ F1 ___ J1 ___ M1 ___ Other _____
Name of School or Institution of International Assignment _____
Country of Destination _____
Participant Status: ___ Student ___ Faculty ___ Scholar ___ Other _____

Address for Correspondence: c/o Name _____
Address _____
City _____ State _____ Zip Code _____
Work Phone (_____) _____ Home Phone (_____) _____
Fax _____ Email _____

Beneficiary Name _____ Relationship _____

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 _____ Months
(minimum 1, Maximum 12)

Note: This Plan is not available in all states, please refer to period of coverage section or contact Koster Insurance Agency for this information. Insurance cannot begin prior to the date the premium and Enrollment Form are received by Koster Insurance Agency. **These rates are valid for coverage through May 31, 2008.**

Calculating Your Premium

Select Coverage Type: Participant Only Spouse/Child (Per Person)
(Dependent coverage is available only if the student/scholar is enrolled for coverage)

Name	Sex	Date of Birth (Month/Day/Year)
Student/Scholar	_____	_____
Spouse	_____	_____
Child	_____	_____
Child	_____	_____

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

Premium Calculation: \$ _____ x _____ = _____
Monthly Premium Number of Months Total Premium Enclosed

I hereby subscribe to the Trustee of the ACE USA Student Insurance Trust. I understand that this policy will not pay benefits for any loss incurred during the first two (2) years of coverage on account of disease or physical condition that I now have or have had in the past two (2) years. I also understand that if it is discovered that I do not meet the eligibility 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 disclose information about you.

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

My signature below certifies that I have read and understand the International Student & Scholars Plan brochure and agree to accept as applicable to me the terms and conditions stated herein."

Signature of Participant _____ Date _____

Method of Payment: Make Check or Money Order payable to Koster Insurance Agency. Total premium for Full Term of insurance requested must be made in U.S. Dollars at the time application for coverage is made. Coverage purchased by credit card is subject to validation and acceptance by credit card company.

___ Check ___ Money Order ___ MasterCard ___ Visa Card # _____

Expiration Date _____ Daytime Phone (_____) _____ Name as it appears on card _____

Billing Address _____

I understand that the premium is non-refundable except as provided under the section entitled Refund of Premium. My signature indicates acceptance of these terms and authorizes Koster Insurance Agency to charge my credit card for the total premium due for the period of coverage requested.

Signature of cardholder _____ Date _____ Policy Form #GLMN0086515