



StudentSecure® Daily

Elite - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 3.06
18-24	\$ 3.06
25-30	\$ 3.06
31-40	\$ 6.64
41-50	\$ 14.93
51-64*	\$ 19.00

Elite - Coverage Including the US

Age	Participant Only
Under 18	\$ 4.41
18-24	\$ 4.41
25-30	\$ 8.94
31-40	\$ 17.82
41-50	\$ 31.43
51-64*	\$ 42.18

Select - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 2.17
18-24	\$ 2.17
25-30	\$ 2.17
31-40	\$ 4.73
41-50	\$ 10.65
51-64*	\$ 13.58

Select - Coverage Including the US

Age	Participant Only
Under 18	\$ 2.93
18-24	\$ 2.93
25-30	\$ 6.15
31-40	\$ 12.49
41-50	\$ 22.19
51-64*	\$ 29.92

Budget - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 1.15
18-24	\$ 1.15
25-30	\$ 1.28
31-40	\$ 2.93
41-50	\$ 7.36
51-64*	\$ 9.99

Budget - Coverage Including the US

Age	Participant Only
Under 18	\$ 1.28
18-24	\$ 1.28
25-30	\$ 2.47
31-40	\$ 5.95
41-50	\$ 10.59
51-64*	\$ 14.24

Smart - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 0.79
18-24	\$ 0.79
25-30	\$ 0.99
31-40	\$ 2.17
41-50	\$ 3.88
51-64*	\$ 5.62

Smart - Coverage Including the US

Age	Participant Only
Under 18	\$ 0.95
18-24	\$ 0.95
25-30	\$ 1.94
31-40	\$ 4.31
41-50	\$ 7.56
51-64*	\$ 10.22

Rates are effective 05/01/2018. Rates are subject to change.

* Applicants 65+ years of age may contact an HCC representative for further assistance.

To be eligible for a full refund, the request for cancellation must be received prior to the policy effective date. Cancellation requests received after the policy effective date will be subject to the following conditions: (1) A \$25 cancellation fee will apply (2) Only the unused portion of the plan cost will be refunded (unused (whole-months in the case of Monthly Payments) (3) Only members who have no claims are eligible for premium refund (4) After 60 days, no refunds are granted



StudentSecure® Monthly

Elite - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 93.00
18-24	\$ 93.00
25-30	\$ 93.00
31-40	\$ 202.00
41-50	\$ 454.00
51-64*	\$ 578.00

Elite - Coverage Including the US

Age	Participant Only
Under 18	\$ 134.00
18-24	\$ 134.00
25-30	\$ 272.00
31-40	\$ 542.00
41-50	\$ 956.00
51-64*	\$ 1,283.00

Select - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 66.00
18-24	\$ 66.00
25-30	\$ 66.00
31-40	\$ 144.00
41-50	\$ 324.00
51-64*	\$ 413.00

Select - Coverage Including the US

Age	Participant Only
Under 18	\$ 89.00
18-24	\$ 89.00
25-30	\$ 187.00
31-40	\$ 380.00
41-50	\$ 675.00
51-64*	\$ 910.00

Budget - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 35.00
18-24	\$ 35.00
25-30	\$ 39.00
31-40	\$ 89.00
41-50	\$ 224.00
51-64*	\$ 304.00

Budget - Coverage Including the US

Age	Participant Only
Under 18	\$ 39.00
18-24	\$ 39.00
25-30	\$ 75.00
31-40	\$ 181.00
41-50	\$ 322.00
51-64*	\$ 433.00

Smart - Coverage Excluding the US

Age	Participant Only
Under 18	\$ 24.00
18-24	\$ 24.00
25-30	\$ 30.00
31-40	\$ 66.00
41-50	\$ 118.00
51-64*	\$ 171.00

Smart - Coverage Including the US

Age	Participant Only
Under 18	\$ 29.00
18-24	\$ 29.00
25-30	\$ 59.00
31-40	\$ 131.00
41-50	\$ 230.00
51-64*	\$ 311.00

Rates are effective 05/01/2018. Rates are subject to change.

* Applicants 65+ years of age may contact an HCC representative for further assistance.

To be eligible for a full refund, the request for cancellation must be received prior to the policy effective date. Cancellation requests received after the policy effective date will be subject to the following conditions: (1) A \$25 cancellation fee will apply (2) Only the unused portion of the plan cost will be refunded (unused (whole-months in the case of Monthly Payments) (3) Only members who have no claims are eligible for premium refund (4) After 60 days, no refunds are granted

StudentSecure® Application
Tokio Marine HCC - Medical Insurance Services Group
Lloyd's Coverholder

Enrollment Information – Please complete all sections.				
Name (First and Last)	Date of Birth (MM/DD/YYYY)	Gender	Citizenship	U.S. Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No U.S. citizens/residents must select "No"
Participant				Plan Level: <input type="checkbox"/> Elite <input type="checkbox"/> Select <input type="checkbox"/> Budget <input type="checkbox"/> Smart Buy-Ups (not applicable with Smart or Budget): <input type="checkbox"/> Crisis Response <input type="checkbox"/> Accidental Death & Dismemberment
Complete Mailing Address				Plan Selections – Single Payment OR Monthly Payments. <input type="checkbox"/> Single Payment – I want to pay in full now. (Must include any purchased Buy-Up rates also, if applicable.) Buy-Ups + Daily cost (refer to rate tables): _____ Multiply by # of days to be covered: x _____ Florida Surplus Lines Tax: x 1.051 Applies if: <input type="checkbox"/> FL Resident <input type="checkbox"/> FL Destination Total amount due: _____
				<input type="checkbox"/> Monthly Payments – I will be automatically charged monthly. (Must include any purchased Buy-Up rates also, if applicable.) Buy-Ups + Monthly cost (refer to rate tables): _____ Florida Surplus Lines Tax: x 1.051 Applies if: <input type="checkbox"/> FL Resident <input type="checkbox"/> FL Destination Add administrative charge: + \$5.00 Monthly amount due (This amount will be charged <u>each</u> month, including the first): _____ # of months to be covered: _____
Email		Telephone		
Name of School/Organization		Home Country		
State (if in US)		Host Country		
<input type="checkbox"/> High School/Secondary <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Scholar	Number of Hours Enrolled: _____	Type of Visa (I-94) <i>Non-US Citizens Only</i> <input type="checkbox"/> F-1 <input type="checkbox"/> M-1 <input type="checkbox"/> J-1 <input type="checkbox"/> R-1		
Coverage Start Date ____/____/____	Date Classes Begin ____/____/____	Coverage End Date ____/____/____		
Payment Method: <input type="checkbox"/> Check/Money Order <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express <input type="checkbox"/> Visa				
Credit Card #:		Expiration Date:		Complete Billing Address:
Name as it appears on card:				
Signature:			Daytime Phone Number:	
Payment by Credit Card* : By signing above, the cardholder authorizes Tokio Marine HCC - Medical Insurance Services Group to debit his or her Discover, VISA, MasterCard or American Express account for the amount specified above. Please submit this completed Application by mail or by fax to your Agent or to Tokio Marine HCC - MIS Group. Tokio Marine HCC - Medical Insurance Services Group 251 N. Illinois Street, Suite 600 Indianapolis, IN 46204				Checks and Money Orders should be made payable to HCC Medical Insurance Services. Please send your Check or Money Order along with this Application via mail or courier to: HCC Medical Insurance Services 15748 Collection Center Dr. Chicago, IL 60693-0157
*If I have selected a monthly plan, I hereby request and authorize Tokio Marine HCC - Medical Insurance Services Group 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 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 this insurance contains a Pre-existing Condition exclusion and other restrictions and exclusions. I understand that, prior to my current coverage expiration date, I can visit the Tokio Marine HCC – MIS Group Client Zone for transaction instructions regarding policy extensions and/or renewal eligibility. 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 Tokio Marine HCC - Medical Insurance Services Group. 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 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 agents are compensated through commissions calculated as a percentage of premium for the purchase, renewal, placement or servicing of insurance coverage. Additionally, some licensed producers may also receive bonuses and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume or for the percentage of completed sales through Tokio Marine HCC - Medical Insurance Services Group. Please contact your insurance broker to obtain information about the specific compensation they may receive in connection with the issuance of your coverage. If signed by a representative of the Applicant, the undersigned warrants his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned warrants his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant.				
Signature of Applicant:				Date of Signature:
Signature of Parent/Guardian (if applicable):				Date of Signature:

For more information or for assistance completing this application, please contact:

HCC Medical Insurance Services
 Phone: 800-605-2282
 E-mail: orders@hccmis.com

Producer Number: 24878