2014-2015
FLORIDA ATLANTIC UNIVERSITY
International Student
Health Insurance Program Highlights

Underwritten by:
AETNA LIFE INSURANCE COMPANY (ALIC)
Group Number # 867855

- Maximum Benefit per Sickness or Injury - **UNLIMITED**
- $400 Annual Deductible (**waived for in-network physician visits for covered sickness & injuries**)
- 100% Coverage at Student Health Center for covered benefits
- Benefits payable at 80% of benefit limits within the Aetna Network of Providers and 70% at an Out of Network Provider
- Routine Care/Annual Physicals covered at 100% in network with deductible waived and no copay
- No Pre-existing Condition Period
- Prescription Coverage with reduced copayments available at the FAU Pharmacy
- Student Assistance Plan and Informed Health Line services provide 24 hour access to health professionals and registered nurses
- Dependent coverage available to Enrolled Students

Our on-campus office is located inside the Student Health Center on the Boca Raton Campus in the Health Services Building SS-8 (above Starbucks). The insurance representative is always available on Thursdays from 1 pm to 4 pm and during heavy enrollment periods.

INSURANCE FOR STUDENTS, INC
5295 Town Center Rd, Suite 101 Boca Raton, FL 33486
1-561-300-5677 (fax) 954-772-0872
Office hours - Monday to Friday 8 am to 5 pm

www.insuranceforstudents.com

FLORIDA ATLANTIC UNIVERSITY

2014-15 INTERNATIONAL STUDENT ENROLLMENT FORM

AETNA LIFE INSURANCE COMPANY (ALIC) GROUP NUMBER 867855

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

STUDENT/SCHOLAR Last Name: School I.D. #

First Name: Middle Initial:

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

Mailing Address: HOME COUNTRY:

City: State: Zip

Phone # ( ) **EMAIL ADDRESS**:

DEPENDENTS - Complete information below for dependents to be insured

NOTE: Dependent Coverage is available only for students/scholars insured under this plan.

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 PLEASE CHECK APPROPRIATE BOX

Accident /Sickness coverage including Medical Evacuation/Repatriation

INTERNATIONAL STUDENT ☐ **GRADUATE** ☐**UNDERGRADUATE**

	Annual	Semi -Annual Session 1	Semi -Annual Session 2
Student	☐$1,350.00	☐$ 680.00	☐$ 670.00
Spouse	☐$3,180.00	☐$1,603.00	☐$1,577.00
Each Child	☐$2,008.00	☐$1,012.00	☐$ 996.00
All Child(ren)	☐$3,960.00	☐$1,994.00	☐$1,964.00

Annual Coverage	Semi-Annual Session 1	Semi-Annual Session 2
8/17/2014 to 8/16/2015	**8/17/2014 to 2/16/2015**	**2/17/2015 to 8/16/2015**

Medical Evacuation / Repatriation ONLY

ANNUAL COVERAGE 8/17/2014 to 8/16/2015 STUDENT ONLY ☐ $66.00

PAYMENT INSTRUCTIONS

Please include a processing fee for credit & debit card payments ONLY

☐ $35 (Annual coverage) ☐ $20 (Semi-Annual)

TOTAL PREMIUM DUE $_____

METHOD OF PAYMENT [ ] CHECK [ ] MONEY ORDER Make payable to Student Insurance [ ] Credit Card (fill-out below)

Credit Card Authorization – Please bill my card for my insurance premium shown above **including the appropriate processing fee**

Cardholder Name (Last/First) _____

Card Number: I I I I I I I I I I I I I I I I Expiration Date (mo/year)___ I___ Sec. Code____I

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 ENTRANCE INTO THE ARMED FORCES**.

I understand that I must be an international student/scholar at FAU to purchase this insurance.

Student's Signature Date

FOR QUESTIONS PLEASE CONTACT:

INSURANCE FOR STUDENTS, INC. 5295 TOWN CENTER RD, SUITE 101 BOCA RATON FL 33486

PHONE 561-300-5677 * FAX 954-772-0872

APPLICATIONS CAN BE MAILED TO ADDRESS ABOVE OR

IF PAYING BY CREDIT CARD CAN BE FAXED TO 954-772-0872 / SCANNED & EMAILED TO cbode@insuranceforstudents.com