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STUDENT RESOURCES (SPC) LTD., A UNITEDHEALTH GROUP COMPANY
ENROLLMENT FORM FOR STUDENTS

THE INTERNATIONAL SCHOOL OF MINNESOTA 2018-203151-91

PRIMARY INSURED COMPLETE INFORMATION BELOW FOR STUDENT.		
INTERNATIONAL ID #:	OR STUDENT ID #:	
LAST (FAMILY) NAME:	FIRST (GIVEN) NAME:	MIDDLE INITIAL:
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH: (MONTH/DAY/YEAR)	EXPECTED DATE OF GRADUATION: (MONTH/YEAR)
MAILING U.S. ADDRESS: (HOUSE/BUILDING # AND STREET NAME)		
CITY:	STATE:	ZIP CODE:
TELEPHONE #:	EMAIL ADDRESS:	

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.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information may be subject to criminal and/or civil penalties.

Student's Signature: ______________________________ Date: ______________

Campus/School Attending: The International School of Minnesota

☐ **I elect to purchase Injury and Sickness insurance coverage. Below are the choices I have made.**

Please check all appropriate boxes.
INSURED CATEGORY: ☐ ITL

	Twelve Month (ZY)	On Campus – 10 Month	Off Campus – 10 Month	Daily (NX)
Student:	☐ $728.00	☐ $596.97	☐ $582.90	☐ $2.01

Student wants to purchase using Coverage Periods

EFFECTIVE/EXPIRATION PERIODS:

- ☐ Annual 8/23/2018 to 8/22/2019
- ☐ On Campus – 10 Month 8/23/2018 to 6/15/2019
- ☐ Off Campus – 10 Month 8/27/2018 to 6/12/2019

Student wants to purchase using Daily Rate

EFFECTIVE AND TERMINATION DATES NOTICE: Coverage will become effective on the date the correct amount due is received by Student Resources (SPC) Ltd., a UnitedHealth Group Company, or the Requested Effective Date below, whichever is later. Coverage will not be effective prior to August 23, 2018 or extend beyond August 22, 2019 There is a minimum of three (3) months enrollment in this plan. Twelve (12) months is the maximum time coverage can be effective under any policy year.

Requested Effective Date: _____/_____/_____

Please Note: If application and correct premium are received after this requested effective date, your effective date will be the date application and correct premium are received.

To calculate your rate:
Rate x # of days eligible = amount due
Example: $2.01 x 90 days = $180.90

CALCULATION FOR DAILY PREMIUM

Daily premium: $______________

Multiply by # of days: ______________

Total premium enclosed: $______________

Payment Instructions: Make check or money order payable to PGH Global in US dollars. Mail this enrollment card along with premium payment to:
PGH Global
67 West Court Street
Doylestown, PA 18901

Your cancelled check or credit card billing is your only receipt and notification of coverage. The student is responsible for timely premium payments whether or not a premium notice is received.

CHARGE CARD AUTHORIZATION INFORMATION

CHARGE FULL AMOUNT $ _______________ ☐ VISA or ☐ MASTERCARD # ______________________ Expiration Date _____-_____ Month Year Security Code __________

AUTHORIZED SIGNATURE________________________________ DATE_____________________

OR PAID BY CHECK #________________________________ AMOUNT PAID $________._______