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
Participant			

U.S. Coverage: □ Yes □ No
U.S. citizens/residents must select "No"

Plan Level: □ Elite □ Select □ Budget □ Smart

Buy-Ups *(not applicable with Smart or Budget):*
□ Crisis Response □ Accidental Death & Dismemberment

Complete Mailing Address

Email | Telephone

Name of School/Organization | Home Country

State (if in US) | Host Country

□ High School/Secondary
□ Undergraduate
□ Graduate
□ Scholar

Number of Hours Enrolled: _____

Type of Visa (I-94)
Non-US Citizens Only
□ F-1 □ M-1
□ J-1 □ R-1

Coverage Start Date	Date Classes Begin	Coverage End Date
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

Plan Selections – Single Payment OR Monthly Payments.

□ **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: □ FL Resident □ FL Destination

Total amount due: _____

□ **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: □ FL Resident □ FL Destination

Add administrative charge: + $5.00

Monthly amount due (*This amount will be charged each month, including the first*): _____

# of months to be covered: _____

Payment Method: □ Check/Money Order □ Discover □ MasterCard □ American Express □ Visa

Credit Card #: | Expiration Date:

Name as it appears on card:

Signature:

Complete Billing Address:

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: **Producer Number:** _____