

**StudentSecureSM Application
HCC Medical Insurance Services
Lloyd's Coverholder**

Enrollment Information – Please complete all sections. Enter Spouse and Child details only for dependents to be covered under this plan.				Plan Selections – Please make a selection in each section. Choose single OR monthly payments.	
Name (First and Last)	Date of Birth (MM/DD/YYYY)	Gender	Citizenship	Type of coverage selected: <input type="checkbox"/> Student Only <input type="checkbox"/> Student & Spouse <input type="checkbox"/> Student & Children <input type="checkbox"/> Student & Family	
Participant				Requested Effective Date: ____ / ____ / 20__	
Spouse				Plan level selected: <input type="checkbox"/> Select <input type="checkbox"/> Budget	
Child				US Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No (US citizens/residents must select "No")	
Child				<input type="checkbox"/> Single Payment – I want to pay in full now.	
Child				Monthly cost from rate tables on page 8: _____	
Complete Mailing Address			Home Country	Multiply by # of months to be covered: x _____	
			Host Country	Total amount due: _____	
Email			Telephone	<input type="checkbox"/> Monthly Payments – I want to be automatically charged each month.	
Name of University	State (if in US)	Type of Visa (I-94) <i>Non-US Citizens Only</i>		Monthly cost from rate tables on page 8 (This amount will be charged now): _____	
<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Scholar Number of Hours Enrolled _____		<input type="checkbox"/> F-1 <input type="checkbox"/> M-1 <input type="checkbox"/> J-1 <input type="checkbox"/> R-1		Add \$5.00 administrative charge: + 5.00	
Date of Departure from Home Country ____ / ____ / ____	Date Classes Begin ____ / ____ / ____	Date of Return to Home Country ____ / ____ / ____		Monthly amount due (This amount will be charged <u>each</u> month after the first): _____	
				# of months to be covered: _____	
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 HCCMIS 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: HCC Medical Insurance Services 251 N. Illinois Street, Suite 600 Indianapolis, IN 46204 Fax: 317-262-2140				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: Bank of America Lockbox Services c/o Lockbox # 15748 540 W. Madison, 4th Floor Chicago, IL 60661	
*If I have selected a monthly plan, I hereby request and authorize HCC Medical Insurance Services 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, a Pre-notification Penalty and other restrictions and exclusions. I understand that renewal of this insurance may only be transacted online and will not be effective unless such transaction is made within the six (6) months immediately preceding my current coverage expiration date and confirmed in writing by HCC Medical Insurance Services. 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 HCC Medical Insurance Services. 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 HCC Medical Insurance Services. 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	
Signature of Spouse				Date	

If for more information or for assistance completing this application, please contact:
HCC Medical Insurance Services • 251 North Illinois Street, Suite 600 • Indianapolis, IN 46204
Phone: 800-605-2282 / 317-262-2132 • Fax: 317-262-2140 • E-mail: insurance@hccmis.com

Producer Number: 9800