TOKIO MARINE HCC

Medical Insurance Services Group
251 North Illinois Street, Suite 600, Indianapolis, IN, 46204 USA
Tel: 317-262-2132 Fax: 317-262-2140 Toll Free: 800-605-2282
orders@hccmis.com
hccmis.com

StudentSecure®

Daily

Elite - Coverage Excluding the US

Age	Participant Only
Under 18	$ 3.75
18-24	$ 3.75
25-30	$ 3.75
31-40	$ 8.12
41-50	$ 18.28
51-64*	$ 23.24

Elite - Coverage Including the US

Age	Participant Only
Under 18	$ 5.39
18-24	$ 5.39
25-30	$ 10.95
31-40	$ 21.80
41-50	$ 38.47
51-64*	$ 51.62

Select - Coverage Excluding the US

Age	Participant Only
Under 18	$ 2.17
18-24	$ 2.17
25-30	$ 2.27
31-40	$ 5.33
41-50	$ 11.97
51-64*	$ 15.22

Select - Coverage Including the US

Age	Participant Only
Under 18	$ 2.93
18-24	$ 2.93
25-30	$ 6.44
31-40	$ 14.01
41-50	$ 24.89
51-64*	$ 33.57

Budget - Coverage Excluding the US

Age	Participant Only
Under 18	$ 1.25
18-24	$ 1.25
25-30	$ 1.41
31-40	$ 3.25
41-50	$ 9.01
51-64*	$ 12.23

Budget - Coverage Including the US

Age	Participant Only
Under 18	$ 1.41
18-24	$ 1.41
25-30	$ 2.70
31-40	$ 6.61
41-50	$ 12.95
51-64*	$ 17.42

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 05/15/2019. 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

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StudentSecure®
Monthly

Elite - Coverage Excluding the US

Age	Participant Only
Under 18	$ 114.00
18-24	$ 114.00
25-30	$ 114.00
31-40	$ 247.00
41-50	$ 556.00
51-64*	$ 707.00

Elite - Coverage Including the US

Age	Participant Only
Under 18	$ 164.00
18-24	$ 164.00
25-30	$ 333.00
31-40	$ 663.00
41-50	$ 1,170.00
51-64*	$ 1,570.00

Select - Coverage Excluding the US

Age	Participant Only
Under 18	$ 66.00
18-24	$ 66.00
25-30	$ 69.00
31-40	$ 162.00
41-50	$ 364.00
51-64*	$ 463.00

Select - Coverage Including the US

Age	Participant Only
Under 18	$ 89.00
18-24	$ 89.00
25-30	$ 196.00
31-40	$ 426.00
41-50	$ 757.00
51-64*	$ 1,021.00

Budget - Coverage Excluding the US

Age	Participant Only
Under 18	$ 38.00
18-24	$ 38.00
25-30	$ 43.00
31-40	$ 99.00
41-50	$ 274.00
51-64*	$ 372.00

Budget - Coverage Including the US

Age	Participant Only
Under 18	$ 43.00
18-24	$ 43.00
25-30	$ 82.00
31-40	$ 201.00
41-50	$ 394.00
51-64*	$ 530.00

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

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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: _____/_____/_____

Form of Payment: □ Credit Card □ Check/Money Order

Credit Card #: | Expiration Date (mm/yy):

Signature:

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:
Applies if: □ FL Resident □ FL Destination X 1.051

Total amount due:

□ Monthly Payment - 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:
Applies if: □ FL Resident □ FL Destination X 1.051

Add Administrative charge: + $5.00

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

Number of months to be covered:

Name as it appears on card:

Complete Billing Address (include daytime phone #):

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 pecified 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 North 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 slected 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.

Authorization

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 traveling outside my Home Country. I understand that my insurance terminates upon my return to my Home Country unless I qualify for a Benefit Period or Home Country Coverage. 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 if my insurance is not Extended or Renewed prior to or on the current coverage expiration date I must purchase a new policy in order to have coverage. 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 - MIS Group. It is the responsibility of Indian residents purchasing insurance cover to obtain permission from the Central Government and Reserve Bank of India. 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. 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. Rates include surplus lines taxes and fees where applicable. **Arbitration Notice:** EXCEPT FOR CERTAIN TYPES OF DISPUTES DESCRIBED IN THE "ARBITRATION AND CLASS ACTION WAIVER" IN ARTICLE 11, AND IF YOU DO NOT OPT-OUT AS SET FORTH IN THAT SAME SECTION, YOU AGREE THAT DISPUTES BETWEEN YOU AND THE MIS GROUP AND/OR THE UNDERWRITERS WILL BE RESOLVED BY BINDING, INDIVIDUAL ARBITRATION, AND YOU WAIVE YOUR RIGHT TO BRING OR RESOLVE ANY DISPUTE AS, OR PARTICIPATE IN, A CLASS, CONSOLIDATED, REPRESENTATIVE, COLLECTIVE, OR PRIVATE ATTORNEY GENERAL ACTION OR ARBITRATION

Applicant Signature:	Date:	Parent/Guardian Signature (if applicable):	Date:

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

Producer Number: _____