# U.S. Students Abroad Health Plan

## Enrollment Form

**PLEASE PRINT - ANSWER ALL QUESTIONS. YOUR APPLICATION WILL BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.**
Price includes membership fee for the Global Citizens Association.

### PERSONAL INFORMATION

Name of Participant _____ Gender: ❑ M ❑ F Date of Birth _____
(First) (Middle) (Last) (Month) (Day) (Year)

Mailing Address _____
(Street) (Room/Apt.#) (City) (State) (Zip)

Home Phone ( ) _____ Mobile Phone ( ) _____ E-Mail _____

Have you previously been insured by HTH Worldwide Insurance Services? ❑ Yes ❑ No If yes, provide certificate number _____

### ADDITIONAL INFORMATION

Status: ❑ Graduate ❑ Undergraduate ❑ Scholar ❑ Faculty ❑ Trainee ❑ Other (Describe) _____

Home Country _____ Host Country _____

Name of School or Organization Affiliation in Host Country _____

### COVERAGE INFORMATION

I WISH TO ENROLL FOR INSURANCE UNDER THE TERMS OF THE MASTER POLICY AS FOLLOWS:

I want my insurance to begin on _____ and to continue for a period of _____ Months.
(Month) (Day) (Year)

### ACCIDENTAL DEATH AND DISMEMBERMENT

Participant's Beneficiary _____
(Name and Relationship)

| | |
|---|---|
| **MONTHLY PREMIUM** from table on previous panel | $_____ |
| Multiply by Whole Months of coverage | X_____ |
| **Total Premium Enclosed** | $_____ |

I hereby certify that, as the proposed participant, I am a U.S. resident and that I am engaged in international educational activities outside of the United States. Further, I understand that a participant whose coverage under this policy lapses shall be subject to all policy exclusions as of any subsequent effective date, and I understand that the Company will not pay benefits for one (1) year for Pre-Existing Conditions (subject to state law).

Date _____/_____/_____ Signature of Participant _____