

**ENROLLMENT FORM FOR INTERNATIONAL STUDENT/SCHOLAR HEALTH INSURANCE – Value Program Policy # AIH0001676**  
Underwritten by The Insurance Company of the State Of Pennsylvania

Email Address: \_\_\_\_\_

Student/Scholar Name: \_\_\_\_\_  
Last First Middle

Social Security or ID#: \_\_\_\_\_

U.S. Address: \_\_\_\_\_  
Number and Street City State Zip

Male  Female  
( )  
Telephone Number

Length of coverage applied for (total number of months): \_\_\_\_\_ NOT BEYOND 9/01/06 Date of Birth: \_\_\_\_\_

Requested effective date\*: \_\_\_\_\_ \*Effective date will be date requested or date proper premium and enrollment form(s) are received, whichever is later.

STUDENT MONTHLY RATES*		DEPENDENT MONTHLY RATES		
Up to age 25 .....	\$55.00	Spouse .....	\$270.00	Charge Card Authorization on back.
Age 26 to 34 .....	\$80.00	Child(ren) .....	\$68.00	
Age 35 to 49 .....	\$135.00			
Age 50 to 64 .....	\$233.00	*Includes AD&D Coverage		<b>TOTAL PREMIUM PAID:</b> _____
Age 65 and over .....	\$430.00	(for students only)		

Make checks payable to "The Insurance Company of the State of Pennsylvania" and mail to: Macori Administration, P.O. Box 2567, Spring, Texas 77383-2567.

*I have read the brochure and elect to enroll myself and (if applicable) my dependents as shown on the reverse side.*

Signature of Student/Scholar: \_\_\_\_\_  
IVPE-03 -- See Reverse Side --

Date: \_\_\_\_\_

**NAMES OF DEPENDENTS FOR WHICH PREMIUM IS ENCLOSED:**

Dependent Names	Relationship to Student	Sex	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTE: Student must be enrolled in order to enroll his or her eligible dependents.

**COMPLETE THIS SECTION ONLY IF PAYING PREMIUM WITH A CREDIT CARD.**

*I authorize The Insurance Company of the State of Pennsylvania to charge my student insurance premium totaling \$\_\_\_\_\_ to:*

Visa  MasterCard Account Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name of Cardholder: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_ Date: \_\_\_\_\_