

StudentSecure[®]

Daily

Select – Coverage Excluding the US

| Age | Participant Only | Participant & Spouse | Participant & Child | Participant & Family |
|----------|--|----------------------|---------------------|----------------------|
| Under 19 | \$ 2.04 | | | |
| 19-24 | \$ 2.04 | \$ 8.75 | \$ 5.29 | \$ 12.30 |
| 25-30 | \$ 2.04 | \$ 12.79 | \$ 6.77 | \$ 16.96 |
| 31-40 | \$ 4.44 | \$ 18.97 | \$ 8.28 | \$ 24.03 |
| 41-50 | \$ 9.96 | \$ 23.28 | \$ 11.84 | \$ 27.16 |
| 51-64 | \$ 12.69 | \$ 25.22 | \$ 13.84 | \$ 30.08 |
| 65+ | Contact HCC Medical Insurance Services | | | |

Budget – Coverage Excluding the US

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 1.18 |
| 19-24 | \$ 1.18 |
| 25-30 | \$ 1.18 |
| 31-40 | \$ 2.73 |
| 41-50 | \$ 6.87 |
| 51-64 | \$ 9.34 |
| 65+ | Contact HCC MIS |

Select – Coverage Including the US

| Age | Participant Only | Participant & Spouse | Participant & Child | Participant & Family |
|----------|--|----------------------|---------------------|----------------------|
| Under 19 | \$ 2.73 | | | |
| 19-24 | \$ 2.73 | \$ 11.70 | \$ 7.07 | \$ 16.41 |
| 25-30 | \$ 4.27 | \$ 17.13 | \$ 8.98 | \$ 22.62 |
| 31-40 | \$ 9.40 | \$ 25.41 | \$ 11.08 | \$ 32.02 |
| 41-50 | \$ 14.47 | \$ 31.20 | \$ 15.81 | \$ 36.16 |
| 51-64 | \$ 18.08 | \$ 33.80 | \$ 18.51 | \$ 40.08 |
| 65+ | Contact HCC Medical Insurance Services | | | |

Budget – Coverage Including the US

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 1.48 |
| 19-24 | \$ 1.48 |
| 25-30 | \$ 3.25 |
| 31-40 | \$ 6.97 |
| 41-50 | \$ 9.70 |
| 51-64 | \$ 13.48 |
| 65+ | Contact HCC MIS |

Smart – Excluding US Coverage

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 0.89 |
| 19-24 | \$ 0.89 |
| 25-30 | \$ 1.02 |
| 31-40 | \$ 2.04 |
| 41-50 | \$ 3.62 |
| 51-64 | \$ 5.26 |

Smart – Including US Coverage

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 0.99 |
| 19-24 | \$ 0.99 |
| 25-30 | \$ 2.17 |
| 31-40 | \$ 4.11 |
| 41-50 | \$ 7.73 |
| 51-64 | \$ 10.39 |

Rates are effective 04/01/2014. Rates are subject to change.

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 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

(03/25/2014)

StudentSecure®

Monthly

Select – Coverage Excluding the US

| Age | Participant Only | Participant & Spouse | Participant & Child | Participant & Family |
|----------|--|----------------------|---------------------|----------------------|
| Under 19 | \$ 62.00 | | | |
| 19-24 | \$ 62.00 | \$ 266.00 | \$ 161.00 | \$ 374.00 |
| 25-30 | \$ 62.00 | \$ 389.00 | \$ 206.00 | \$ 516.00 |
| 31-40 | \$ 135.00 | \$ 577.00 | \$ 252.00 | \$ 713.00 |
| 41-50 | \$ 303.00 | \$ 708.00 | \$ 360.00 | \$ 826.00 |
| 51-64 | \$ 386.00 | \$ 767.00 | \$ 421.00 | \$ 915.00 |
| 65+ | Contact HCC Medical Insurance Services | | | |

Budget – Coverage Excluding the US

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 36.00 |
| 19-24 | \$ 36.00 |
| 25-30 | \$ 36.00 |
| 31-40 | \$ 83.00 |
| 41-50 | \$ 209.00 |
| 51-64 | \$ 284.00 |
| 65+ | Contact HCC MIS |

Select – Coverage Including the US

| Age | Participant Only | Participant & Spouse | Participant & Child | Participant & Family |
|----------|--|----------------------|---------------------|----------------------|
| Under 19 | \$ 83.00 | | | |
| 19-24 | \$ 83.00 | \$ 356.00 | \$ 215.00 | \$ 499.00 |
| 25-30 | \$ 130.00 | \$ 521.00 | \$ 273.00 | \$ 688.00 |
| 31-40 | \$ 286.00 | \$ 773.00 | \$ 337.00 | \$ 974.00 |
| 41-50 | \$ 440.00 | \$ 949.00 | \$ 481.00 | \$ 1,100.00 |
| 51-64 | \$ 550.00 | \$ 1,028.00 | \$ 563.00 | \$ 1,219.00 |
| 65+ | Contact HCC Medical Insurance Services | | | |

Budget – Coverage Including the US

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 45.00 |
| 19-24 | \$ 45.00 |
| 25-30 | \$ 99.00 |
| 31-40 | \$ 212.00 |
| 41-50 | \$ 295.00 |
| 51-64 | \$ 410.00 |
| 65+ | Contact HCC MIS |

Smart – Excluding US Coverage

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 27.00 |
| 19-24 | \$ 27.00 |
| 25-30 | \$ 31.00 |
| 31-40 | \$ 62.00 |
| 41-50 | \$ 110.00 |
| 51-64 | \$ 160.00 |

Smart – Including US Coverage

| Age | Participant Only |
|----------|------------------|
| Under 19 | \$ 30.00 |
| 19-24 | \$ 30.00 |
| 25-30 | \$ 66.00 |
| 31-40 | \$ 125.00 |
| 41-50 | \$ 235.00 |
| 51-64 | \$ 316.00 |

Rates are effective 04/01/2014. Rates are subject to change.

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 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

(03/25/2014)

**StudentSecure® Application
HCC Medical Insurance Services
Lloyd's Coverholder**

| | | | | |
|--|--------------------------------------|--|--------------------|--|
| Enrollment Information – Please complete all sections. Note: Enter Spouse and Child details only for dependents to be covered, if any. | | | | |
| Name (First and Last) | Date of Birth (MM/DD/YYYY) | Gender | Citizenship | U.S. Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>U.S. citizens/residents must select "No"</i> |
| Participant | | | | Type of Coverage <i>Dependent coverage ONLY available under Select plan</i> |
| Spouse | | | | <input type="checkbox"/> Student Only <input type="checkbox"/> Student & Spouse <input type="checkbox"/> Student & Children <input type="checkbox"/> Student & Family |
| Child | | | | Plan Level: <input type="checkbox"/> Select <input type="checkbox"/> Budget <input type="checkbox"/> Smart |
| Child | | | | Plan Selections – Single Payment OR Monthly Payments. |
| Child | | | | <input type="checkbox"/> Single Payment – I want to pay in full now. |
| Complete Mailing Address | | | | Daily cost (refer to rate table): _____ |
| Email | | Telephone | | Multiply by # of days to be covered: x _____ |
| Name of University | | Home Country | | Florida Surplus Lines Tax: x 1.05175 Applies if: <input type="checkbox"/> FL Resident <input type="checkbox"/> FL Destination |
| State (if in US) | | Host Country | | Total amount due: _____ |
| <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input type="checkbox"/> Scholar | Number of Hours Enrolled: _____ | Type of Visa (I-94) <i>Non-US Citizens Only</i> <input type="checkbox"/> F-1 <input type="checkbox"/> M-1 <input type="checkbox"/> J-1 <input type="checkbox"/> R-1 | | <input type="checkbox"/> Monthly Payments – I will be automatically charged monthly. |
| Coverage Start Date ____/____/____ | Date Classes Begin ____/____/____ | Coverage End Date ____/____/____ | | Monthly cost (refer to rate table): _____ |
| 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 | | | | Florida Surplus Lines Tax: x 1.05175 Applies if: <input type="checkbox"/> FL Resident <input type="checkbox"/> FL Destination Add administrative charge: + \$5.00 |
| Credit Card #: | Expiration Date: | Complete Billing Address: | | |
| Name as it appears on card: | | Daytime Phone Number: | | |
| Signature: | | <p>Payment by Credit Card*: By signing above, the cardholder authorizes HCC Medical Insurance Services 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 HCCMIS. HCC Medical Insurance Services 251 N. Illinois Street, Suite 600 Indianapolis, IN 46204</p> <p>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</p> | | |
| *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 of Signature: |
| Signature of Spouse: | | | | Date of Signature: |

For more information or for assistance completing this application, please contact:
DNP INSURANCE SERVICES / DNP & Associates, Inc. / 14541 Brookhurst St. Ste. C2
Westminster, CA 92683 USA
Phone: 714-531-8750 || Fax: 714-531-8752
E-mail: dnpinsurance@yahoo.com
www.dnpGlobal.com

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