HCC Medical Insurance Services, LLC
251 North Illinois Street, Suite 600, Indianapolis, Indiana 46204 USA
main 317 262 2132 facsimile 317 262 2140 toll free 800 605 2282
hccmis.com service@hccmis.com

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)

HCC Medical Insurance Services, LLC (HCCMIS®) is a service company that is a subsidiary of HCC Insurance Holdings Inc. HCCMIS has authority to enter into contracts of insurance on behalf of the Lloyd's underwriting members of Lloyd's Syndicate 4141, which is managed by HCC Underwriting Agency Ltd.

HCC

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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.

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(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)

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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
Participant			
Spouse			
Child			
Child			
Child			

U.S. Coverage: ☐ Yes ☐ No
U.S. citizens/residents must select "No"

Type of Coverage
Dependent coverage ONLY available under Select plan
☐ Student Only ☐ Student & Spouse
☐ Student & Children ☐ Student & Family

Plan Level: ☐ Select ☐ Budget ☐ Smart

Plan Selections – Single Payment OR Monthly Payments.

☐ **Single Payment –** I want to pay in full now.

Daily cost (refer to rate table): _______
Multiply by # of days to be covered: x _______
Florida Surplus Lines Tax: x 1.05175
Applies if: ☐ FL Resident ☐ FL Destination
Total amount due: _______

☐ **Monthly Payments –** I will be automatically charged monthly.

Monthly cost (refer to rate table): _______
Florida Surplus Lines Tax: x 1.05175
Applies if: ☐ FL Resident ☐ FL Destination
Add administrative charge: + $5.00
Monthly amount due (*This amount will be charged each month, including the first*): _______
# of months to be covered: _______

Complete Mailing Address

Email

Telephone

Name of University

Home Country

State (if in US)

Host Country

☐ 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
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____

Payment Method: ☐ Check/Money Order ☐ Discover ☐ MasterCard ☐ American Express ☐ 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 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

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 of Signature:
Signature of Spouse:	Date of Signature:

For more information or for assistance completing this application, please contact: **Producer Number:** 25455-001

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