

# AIA Policy 3

(StudyUSA Plan A)

## PDF application instructions

*UTA - Fall 2010*

**This application is only for students age 30 to 34. Go to [AIAhealth.com/Paper](http://AIAhealth.com/Paper) to see applications for students of other ages.**

1. You must download and install the latest version of Adobe Reader (Version 9.3.3) to use page 2 of this PDF form. Older versions of Adobe Reader and alternative PDF readers are not 100% compatible with this form. Download Adobe Reader here: <http://get.adobe.com/reader/>
2. Complete **all** fields in the form. If you leave even one field blank, your application will be rejected.
3. After you have completed the form, **SAVE** it, and then email it to [Shane@AIAhealth.com](mailto:Shane@AIAhealth.com). If you can not save the form it is because you are not using the latest version of Adobe Reader.
4. After Shane has received your application will reply to let you know he received it.
5. You must then wait up to 4 business days to receive your documents by email. **UTA students have plenty of time to wait - OIE's Fall 2020 waiver deadline is not until September 13th.**
6. You do not need to print, scan, or fax this form – simply type in your answers, save the file, and email the saved file to Shane. You do not need to sign this form by hand.
7. Yes, you may use a credit card **or** a debit card. Debit cards are allowed now!

**DEADLINE to submit this PDF application to Shane:  
Friday, September 3rd**

# Study USA-HealthCare™ Enrollment Form

Official Use Only: 06/09  
 Conf.#  
 PC# 133020  
 Eff Date: \_\_\_/\_\_\_/\_\_\_  
 Date Rec'd: \_\_\_/\_\_\_/\_\_\_

## 1. Insured's Information (Please Print Clearly)

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State/Province, Zip/Postal Code \_\_\_\_\_  
 Country \_\_\_\_\_  
 Phone \_\_\_\_\_

Email Address \_\_\_\_\_  
 Passport Number \_\_\_\_\_  
 Country Issuing Passport \_\_\_\_\_  
 Visa Type \_\_\_\_\_

- I am an international student currently registered to study in the U.S.  
 I am a U.S. registered student studying outside the U.S.

Name of school, college or university **UT-Arlington**

State your school is located **Texas**

## 2. Enrollment Type

- First Time Enrollment**  
 For Myself  For Myself and Dependents

- Dependent Enrollment Only**

Confirmation Number \_\_\_\_\_

- Renewal** for Self/Dependents

Confirmation Number \_\_\_\_\_

Plan Requested:  Plan A  Plan B

Months of Coverage (maximum 12 months): **5**

Requested Effective Date: (month/day/year) **8 / 17 2010**

## 3. Payment Choose one method.

- Enroll by Mail  
 Payment:  check  credit card

- Enroll by Fax:  
 Pay with credit card only (DO NOT mail originals.)

Credit Card Type  Visa  MasterCard  Discover

Card # \_\_\_\_\_ Exp. \_\_\_ / \_\_\_

Card Holder Name \_\_\_\_\_

Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_

## 4. Rate Calculation

Name - Complete the form below for yourself and any dependents you are enrolling.	Arrival Date in Country of Study (month/day/year)	Monthly Premium	Total Monthly Premium	# of Months (max.12)	Total Payment
Insured Name _____	___/___/___	\$ <b>70</b>	= \$ <b>70</b>	x <b>5</b>	= <b>350</b>
Insured Date of Birth (month/day/year) ___/___/___					
Spouse Name _____	___/___/___	\$ _____	= \$ _____	x _____	= <b>0</b>
Spouse Date of Birth (month/day/year) ___/___/___					
Dependent Name _____	___/___/___	\$ _____	= \$ _____	x _____	= <b>0</b>
Dependent Date of Birth (month/day/year) ___/___/___					

**Subtotal = 350**

**Administration Fee + \$ 5.00**

**OPTIONAL:** Include your fax number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ for a rushed fax copy of Confirmation. Add \$10.00 + **0**

I hereby enroll in Study USA-HealthCare. All claims will be fully investigated. Premiums received by the Program Marketer / Insurance Company will be considered fully earned and non-refundable. Coverage under this program terminates if a covered Person enters military service and a pro-rata refund will be made from the date a written request is received. Otherwise, no refunds will be made.

**Total \$ 355**

Signature of Insured or Proxy \_\_\_\_\_ Date \_\_\_\_\_