

Application for Plus Scholastic – Oregon Residents

Underwritten By: ACE American Insurance Company – Philadelphia, PA 19106

Mail application to:

MEDEX Insurance Services, Inc.
P.O. Box 19056
Baltimore, MD 21284
Phone: 800-732-5309
Fax: 410-308-7905
8:00 A.M. - 5:00 P.M. ET, Monday - Friday

Application is hereby made for Plus Scholastic based on the following statements and representations:

Applicant 1 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Applicant 2 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Applicant 3 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Applicant 4 Full Name: _____ Date of Birth: _____
 Ms. Mr. (month/day/year)

Permanent Address: _____

State/Province: _____ Postal/Zip Code: _____ Country: _____

Home Phone: _____ Work Phone: _____ Fax: _____

E-Mail: _____

Passport #: _____ Country of Issue: _____

Country(ies) of Destination: _____

Start Date: _____ End Date: _____

Total Number of months of coverage requested: _____

Name of Educational Institution in Host Country: _____

Emergency Contact: _____ Phone Number: _____

Primary Health Insurance Company: _____

Phone Number: _____ Policy: _____

Premium Rates

Calculate Cost of Coverage:

US Citizens Traveling Abroad:

- One month: \$65.00 Six months: \$160.00 Annual: \$225.00
 Four months: \$120.00 Nine months: \$195.00

Visitors to the US:

- Six months: \$48.00 Annual: \$60.00

- Check one: Foreign Nationals Traveling through the US
 US Citizen Traveling Abroad

Such Premiums are due and payable in the following manner: The Applicant agrees to pay, in advance, the required Premium for these coverages.

Coverage is issued according to plan specifications and rates in effect at the time of enrollment.

2. Payment Method

- Check Money Order
 American Express Master Card Visa

Card #: _____ Expiration Date: _____
(month/ year)

Billing Address:

Street: _____

State/Province: _____ Postal/Zip Code: _____ Country: _____

Name as it appears on card: _____ Signature: _____

If paying by credit card, I hereby authorize ACE American Insurance Company or its authorized agents to deduct the total premium due from my credit card.

I understand my information is protected by privacy laws and will be released only in accordance with these laws.

IMPORTANT NOTICE: ANY PERSON WITH THE INTENT TO KNOWINGLY DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO THAT IS RELATED TO THE ACCEPTANCE OF THE RISK BY THE INSURER, MAY BE GUILTY OF INSURANCE FRAUD AND MAY BE SUBJECT TO PROSECUTION.

I certify that I have read the complete plan description, and understand the terms and conditions of coverage that apply to me including any limitations or exclusions that may apply to my coverage. Further, I understand there is no coverage for loss due to pre-existing conditions, unless this insurance is purchased within the required time period to waive the Pre-existing Medical Condition Exclusion.

Applicant's Signature: _____ Date: _____
(month/day/year)