

# International Student Accident and Health Insurance Enrollment Form

**School Information**

Name of School **St. John's Military School**  
 School Mailing Address **PO Box 5020**  
 City **Salina** State **KS** Zip **67402-5020**  
 Contact Name at School **Debby Edgerton** Phone **785-823-7231** x. **7704**  
 FAX **785-309-5489** E-Mail **debbye@sjms.org**

**Student Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_  Male  Female  
 Home Address \_\_\_\_\_ City \_\_\_\_\_  
 Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Home Country \_\_\_\_\_  
 Phone \_\_\_\_\_ FAX \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Type of Visa held  F-1  J-1  \*Other (Specify) \_\_\_\_\_

Coverage will begin on the later of the following:  
 a) The Date of your departure from your Home Country, or b) the date your enrollment form and premium are received by ACE American Insurance Company, or c) the date you become eligible, or d) the date you requested on the enrollment form.

Have you had insurance with us before?  Yes  No Accidental Death Benefit: \_\_\_\_\_  
Beneficiary Relationship

I want my insurance to begin on \_\_\_\_\_ and continue for \_\_\_\_\_ months.  
Month Day Year Maximum 12 months

Plan selection:  Gold \$84.25/month  \_\_\_\_\_ months = \$ \_\_\_\_\_ USD

\*Important Rate Information: Any enrollment form received or effective on or after December 31, 2007 may be subject to new rates.

Method of payment:  Check  Money Order  MasterCard  Visa Card **We do not accept Discover Card or American Express.**

**Credit Card**

If credit card, I authorize ACE to bill my account for the total premium \$ \_\_\_\_\_  
 Card# [ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ] - [ ][ ][ ][ ][ ] Expiration Date: [ ][ ] 20 [ ][ ] Security Code [ ][ ][ ][ ][ ]  
 \_\_\_\_\_   
Name (as it appears on credit card) Signature of card holder

I understand that Benefits are not payable for conditions existing prior to the effective date of coverage (see definition of "Pre-existing Condition"). I hereby subscribe to the ACE USA Accident and Health Insurance Trust and enroll in the coverage for which I am eligible under the blanket policy issued by ACE American Insurance Company. Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Sign**

\_\_\_\_\_   
Date Signature of participant

- Policy Number: GLM N00174646 - P/C 273220 - GEN ●
- Please make check or Money Order payable to:
- Please send payment in **U.S. Dollars.**
- Please mail all enrollment forms, checks, Money Orders, Credit Card payments to:

**U.S. Mail:**  
**St. John's Military School**  
**P.O. Box 5020**  
**Salina, KS 67402-5020**  
**785-823-7231, 866-704-5294**