

REPATRIATION ENROLLMENT FORM

The Policyholder of this Insurance Plan is the Regents of the University of California

PLEASE PRINT – ANSWER ALL QUESTIONS

Last Name (Surname) _____ First Name (Given Name) _____

USA Street Address _____ City, State, Zip Code _____

Male ___ Female ___ Date of Birth -- Month: _____ Day: _____ Year: _____

I want my insurance to start on: Month: _____ Day: _____ Year: _____ And continue for a period of at least _____ months.

University of California, at _____ Passport # _____ Home Country _____

Beneficiary (for Accidental Death Benefit) _____ Relationship to Insured _____

Name of Dependents to be insured:

Spouse _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____
Child _____	Age _____	F _____	M _____

Monthly Premium Rates -- These rates are valid for coverage which has an effective date on or after September 1, 2006. There will be no refund of premium remitted for these coverages.

Eligible Person and Dependents -- \$4.00 per month for the first three months, \$3.00 per month thereafter. Minimum Premium is \$8.00 (2 months); Maximum Premium is \$39.00 (12 months). Payment must cover entire length of stay or up to the 12 month maximum.

I wish to enroll for insurance under the terms of the Master Policy as follows:

	First 3 months		Additional Months (up to 9)
Monthly Premium:	\$ <u>4.00</u>		\$ <u>3.00</u>
Number of Months:	_____		_____
Subtotal Cost:	\$ _____	plus	\$ _____
		Total Cost =	\$ _____

Applicant Signature: _____ Date: _____ Department: _____ Dept. Phone #: _____

Name of Department Administrative Assistant or International Student/ Scholar Advisor: _____ jvisa@ucsc.edu _____

BAB 010113-946

Make check or money order payable to Saylor & Hill Co.

Please submit to: Shannon Turner, Saylor & Hill; 1999 Harrison Street, Suite 1230; Oakland, CA 94612