

**REPATRIATION, MEDICAL EVACUATION, & ACCIDENTAL DEATH &
DISMEMBERMENT INSURANCE PLAN FOR FOREIGN SCHOLARS and
STUDENTS VISITING THE UNITED STATES WHO ARE SPONSORED BY
THE UNIVERSITY OF CALIFORNIA**



ELIGIBILITY FOR COVERAGE

All International students, exchange visitors, visiting faculty members, scholars or other persons with a current passport or Student visa who are temporarily residing outside their Home Country while actively engaged in educational activities or educational research related activities of the Policyholder, and any eligible Dependents.

PERIOD OF INSURANCE

- A. Effective Date of Insurance – Provided the required premium is paid, your insurance will become effective on the later of:
- The Policy Effective Date;
 - 12:01a.m. Standard Time on the date you indicated on the Enrollment Form;
 - 12:01a.m. Standard Time on the Effective Date required by the Member School;
- or
- 12:01a.m. Standard Time on the date the Enrollment Form and premium are received by the Plan Administrator.
- B. Termination of Insurance – Your Insurance will terminate the earlier of:
- 12:01a.m. Standard Time on the date for which your premium has been paid;
 - 12:01a.m. Standard Time on the date you cease to be eligible for this insurance;
 - 12:01a.m. Standard Time on the date you depart your Country Assignment for your Home Country; or
 - 12:01a.m. Standard Time on the date The Policy is terminated.

DEFINITIONS

“***Accident***” means a sudden, unforeseeable external event which:

- 1) causes Injury to one or more Covered Persons; and
- 2) occurs while coverage is in effect for the Covered Person.

“***Covered Person***” means the Insured and any eligible Dependents, as defined, for whom an Enrollment Form is received and the proper premium payment has been made, and who is therefore covered under the Policy.

“Dependent” means:

- 1) the lawful spouse of the Insured;
- 2) the Insured’s unmarried child who chiefly relies on the Insured for support and maintenance and is within the following age groups:
 - under 19 years of age;
 - 19 but less than 25 years of age and is enrolled in a school as a full-time student; or
 - 19 or more years of age, primarily supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child’s condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a Dependent. During the next two years we may, from time to time, require proof of continuation of such condition and dependence. After that, we may require proof no more than once a year. Child includes stepchildren, foster children, legally adopted children, children of adoptive parents pending adoption proceedings, and natural children.

“Injury” means bodily harm which results, directly and independently of all other causes, from a covered Accident. All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

“Sickness” means sickness or disease which begins while coverage is in force under the Policy for the Covered Person. Sickness includes normal and complications of pregnancy. All related conditions and recurring symptoms of sickness will be considered one sickness.

REPATRIATION BENEFIT -- \$10,000 MAXIMUM BENEFIT

If a Covered Person should die from a covered Injury or covered Sickness, benefits will be paid for the usual and customary expenses incurred for the preparation and transportation of your body to your Home Country, not to exceed a maximum benefit of \$10,000. All expenses must be approved by The Plan Administrator before the body is prepared for transportation.

ACCIDENTAL DEATH, DISMEMBERMENT, OR LOSS OF SIGHT BENEFITS

If as a result of a covered Injury, the Covered Person sustains any one of the losses shown below within one year from the date of the covered Accident, benefits will be payable as follows:

Loss of:	
Life	\$10,000
Both Hands	\$10,000
Both Feet	\$10,000
Entire Sight of Both Eyes	\$10,000
One Hand and One Foot	\$10,000

One Hand and Entire Sight of One Eye	\$10,000
One Foot and Entire Sight of One Eye	\$10,000
One Hand	\$ 5,000
One Foot	\$ 5,000
Entire Sight of One Eye	\$ 5,000
Thumb and Index Finger of the same hand	\$ 2,500

If the Covered Person sustains more than one Loss as a result of one Covered Accident, benefits will be payable only for the largest amount to which such Person is entitled.

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint. Loss of sight means total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of a thumb and index finger means complete severance through or above the metacarpophalangeal joints between the fingers and the hand.

“*Severance*” means the complete separation and dismemberment of the part from the body.

MEDICAL EVACUATION BENEFIT -- \$10,000 MAXIMUM BENEFIT

If an emergency evacuation is required due to a covered Injury or a covered Sickness, and a Doctor determines that adequate medical care cannot be performed locally while the Covered Person is outside of his Home Country, benefits will be paid for the Usual and customary expenses incurred, not to exceed the maximum benefit amount of \$10,000.

Benefits will be provided for:

- 1) medical services required for evacuation to the nearest adequate medical facility; and
- 2) escort services, if the Covered Person is disabled and on the recommendation of a Doctor; and
- 3) ambulance service to the nearest airport and air ambulance upon departure; and
- 4) air transportation costs to return the Covered Person to his Home Country, a stretcher, oxygen or other special medical arrangements are covered if the Insured’s Doctor states in writing that such services are medically necessary; and
- 5) expenses above the cost of a return airfare ticket held by the Covered Person, or in the absence of a ticket, the cost of an economy airfare ticket.

EXCLUSIONS (#1 - #3 apply to AD&D only)

Benefits will not be paid for:

- 1) a Covered Person’s loss which is caused by or results from his own:
 - a. Intentionally self-inflicted Injury, suicide or any attempt thereat (in Missouri this applies only while sane);
 - b. Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a Doctor (Accidental ingestion of a poisonous substance is not excluded);

- c. Commission or attempt to commit a felony;
 - d. Participation in a riot or insurrection.
- 2) a Covered Person's loss which is caused by or results from:
 - a. declared or undeclared war or act of war;
 - b. an act of terrorism;
 - c. an Injury sustained while in the service of the Armed Forces of any country.
- 3) An Injury that is caused by flight in an aircraft, except as a fare-paying passenger.
- 4) Charges which:
 - a. The Covered Person would not have to pay if he did not have insurance; or
 - b. are in excess of usual and customary charges.

CLAIMS

Please forward all claims to Saylor & Hill Co., 1939 Harrison Street, #900, Oakland, CA 94612.

PAYMENT OF CLAIMS

Benefits will be paid to the claimant, to the designated beneficiary, or to the estate.

ENROLLMENT PROCEDURE

- 1) Complete the attached enrollment form.
- 2) Make your check payable to Saylor & Hill Co.
- 3) Purchase coverage for **at least** two months **but not more than** twelve months.
- 4) Mail completed enrollment form and check to Saylor & Hill Co.
- 5) Renewals are the responsibility of the applicant.

PREMIUM

The cost of coverage under this Insurance Plan is \$3.00 per month for the Insured and any eligible Dependents. There is a \$1.00 per month administrative fee for the first three months of purchased coverage. The same administrative fee applies to each renewal.

REFUND OF PREMIUM

Premiums received by the Plan Administrator will be considered fully earned and non-refundable.

PRORATION OF PREMIUMS

There will be no proration of premium.



Saylor & Hill Co.

SINCE 1933 – INSURANCE BROKERS
LIC. NO. 0076623

1939 HARRISON STREET, #900
OAKLAND, CALIFORNIA 94612
TELEPHONE 510-273-8888
FAX 510-273-8867

Important Notice

This information provides a brief description of the important features of this Insurance Plan. It is not a contract. Terms and conditions of the coverage are set forth under form number BA-01-1000.

This Insurance Plan is underwritten and offered by the Life Insurance Company of North America, a CIGNA Company, Philadelphia, Pennsylvania.

CIGNA Group Insurance

Life-Accident-Disability

BAB 010113-946

9/06

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: _____

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Make check or money order payable to Saylor & Hill Co. and deliver with this form to your Department Administrative Assistant or International Student/Scholar Office, or mail to Saylor & Hill Co. U.S. FUNDS ONLY.