

**2008 - 2009**



## **Student Insurance Plan**

Policy # CUH 201571

### **Accident and Sickness Insurance for Students and Their Dependents**

This plan is insured by  
Combined Insurance Company of America

Direct All Inquiries Regarding Enrollment to the  
Plan Administrator:

**Associated Insurance Plans International, Inc.**

Post Office Box 189  
Libertyville, IL 60048

(800) 452-5772 • Fax (847) 281-8813  
email: [office@AIPInternational.com](mailto:office@AIPInternational.com)

Please contact us between the hours of  
7:00 a.m. to 7:00 p.m. CST

Student Insurance Information Internet Site:  
[www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)

Pre-certification is not required.  
Policy benefits are not guaranteed.

**Approved and Endorsed by  
Austin Community College**

❖ **Student Insurance Information is available at:**  
[www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)  
800-452-5772

## Insurance Plan Highlights

- Coverage anywhere in the world
- \$50,000 per covered medical condition
- National Preferred Provider Network
- Medical Evacuation, Repatriation and Travel Assistance Benefits
- Accidental Death and Dismemberment Benefits
- Monthly Payment Option

Detach and keep in your possession. Your permanent ID Card may be obtained at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).

### Austin Community College 2008-2009

Student Insurance Identification Card

Combined Insurance Company of America

**NOTE:** In a life threatening emergency, go to the nearest emergency room for treatment.

Print name and school ID number

Policy Number: CUH 201571

\$25 Physicians Visit Co-pay  
\$100 Emergency Room Co-pay

Direct all claim  
inquiries and  
correspondence to: Administrative Concepts, Inc. **Payor #: 22384**  
994 Old Eagle School Road, Suite 1005  
Wayne, PA 19087-1802  
[www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)  
1-800-452-5772

**Beech Street**  
A VIANI NETWORK

This ID card is for identification only. Possession of the card does not guarantee the right to services or other benefits unless the holder is complying with all provisions of the Member Policy and is currently insured on the date of service. Contact Administrative Concepts, Inc. to verify coverage.

Notification of Injury or Sickness must be provided to Administrative Concepts, Inc. within 30 days after the date of accident or the commencement of Sickness. Bills for which benefit is to be paid must be submitted within 90 days of the date of treatment. Pre-certification is not required.

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**AUSTIN COMMUNITY COLLEGE  
STUDENT ACCIDENT AND  
SICKNESS INSURANCE PROGRAM**

*Compare this plan to coverage you may now have!*

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The following is a brief description of the benefits of the Student Accident and Sickness Insurance Program which has been designed for all registered students. This plan is underwritten by COMBINED INSURANCE COMPANY OF AMERICA. The exact provisions governing this insurance are contained in the Master Policy issued to Austin Community College by Combined Insurance Company of America and may be viewed online at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).

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**ELIGIBILITY**

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All registered and enrolled Austin Community College Students are eligible to enroll in this insurance plan (no minimum hour requirement).

Eligible students who enroll may also insure their dependents. Eligible dependents are the spouse (residing with Insured student) and unmarried children under 25 years of age, including an unmarried grandchild under 25 years of age. Dependent coverage starts and expires concurrently with that of the Insured student. If the Insured Person is a covered person prior to the moment of birth, the newborn infant will also be covered under the terms of this policy.

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**EFFECTIVE AND TERMINATION DATES**

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The Master Policy on file at Austin Community College becomes effective 12:00 a.m., August 25, 2008. Coverage becomes effective on that date or the date application and full premium for the term of coverage you have selected is received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m, August 24, 2009. Coverage terminates on that date, or if paying other than annually, at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the insured student. Coverage is in force 24 hours a day, anywhere in the world, for the entire term for which premium has been paid.

Insured Persons entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro-rata refund of premium will be made for such person, upon written request received by the company, within 90 days of withdrawal from school.

Note: The effective date for 2008-2009 precedes the termination date of the 2007-2008 policy. Those students insured for both plan years, will receive the benefits provided by the 2008-2009 policy, if a loss occurs between August 25, 2008 and August 27, 2008.

## PERIODS OF COVERAGE

If paying premiums other than Annual, premiums are due and must be paid as shown below. Please see premiums list at the end of the brochure.

<b>Full Policy Year</b> Enrollment Ends	August 25, 2008 through August 24, 2009 October 15, 2008
<b>Policy Year Paid by Semester</b> Fall Semester Enrollment Ends	August 25, 2008 through January 19, 2009 October 15, 2008
<b>Policy Year Paid by Semester</b> Spring Semester Enrollment Ends	January 20, 2009 through May 31, 2009 March 15, 2009
<b>Policy Year Paid by Semester</b> Spring & Summer Enrollment Ends	January 20, 2009 through August 24, 2009 March 15, 2009
<b>Policy Year Paid by Semester</b> Summer Semester Enrollment Ends	June 1, 2009 through August 24, 2009 Enrollment ends June 15, 2009
<b>Policy Year Paid by Semester</b> Summer Semester I Enrollment Ends	June 1, 2009 through July 7, 2009 Enrollment ends June 15, 2009
<b>Policy Year Paid by Semester</b> Summer Semester II Enrollment Ends	July 8, 2009 through August 24, 2009 Enrollment ends June 15, 2009
<b>Policy Year Paid by Quarter</b> Quarterly Enrollment  Enrollment Ends	Initial payment due August 25, 2008 subsequent payments due November 25, 2008, February 25, 2009, and May 25, 2009.  October 15, 2008 Fall Semester March 15, 2009, Spring Semester
<b>Monthly Payment for Policy Year Coverage</b> (Auto Debit Only) Enrollment Ends	Initial payment due August 24, 2008 subsequent payments debited from your account on the 25th of each month through July 25, 2009. October 15, 2008, Fall Semester March 15, 2009, Spring Semester

## IMPORTANT NOTE

You must meet the eligibility requirements listed in the Eligibility Section. (To avoid a lapse in coverage, your insurance payment must be received within 14 days after the date your coverage terminates, based on the insurance payment method you selected.) It is the student's responsibility to make timely premium payments to the address indicated to avoid a lapse in coverage.

### LATE ENROLLMENT

**Eligible students and their Dependents will not be allowed to enroll in the Policy after October 15, 2008 for Fall Semester, or March 15, 2009 for Spring Semester and for Summer, all premiums are due and must be postmarked by June 15, 2009, unless proof is furnished that the eligible student or Dependent became ineligible for coverage under another insurance policy, during the thirty (30) days immediately preceding the date of the request for late enrollment in the University's Policy. In such cases, the cost will be the same as it would have been at the beginning of that period, but the effective date will be the date the application is made and the payment is received. The deadlines shown above are ABSOLUTE deadlines.**

**THE 14-DAY GRACE PERIOD DOES NOT APPLY HERE.**

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## **REFUND OF PREMIUM**

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Premiums received by Us will be considered fully earned and nonrefundable. Refund of premium will be considered only if the Insured Person enters the Armed Forces.

Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request and coverage will end as of the date of such entry.

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## **EXTENSION OF BENEFITS**

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If an Insured Person is totally disabled at the date of discontinuance of the Policy, charges incurred during the continuation of such total disability shall also be included in the term "Expense", but only while they are incurred during the lessor of the duration of such disability or the 90 day period following the discontinuance of the Policy.

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## **TERMINATION OF INSURANCE**

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Benefits are payable under the Policy only for those Covered Expenses incurred while the Policy is in effect as to the Insured Person. No benefits are payable for Expenses incurred after the date the Insurance terminates for the Insured Person.

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## **CONTINUATION PLAN**

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If you graduate, leave, or terminate from Austin Community College, you may continue to be covered under this plan for the remainder of the Policy year at premiums shown. If continuous coverage is maintained, you can re-enroll in the insurance plan for one additional Policy year at a higher premium subject to the terms of the Policy in effect. Request for continuation and payment must be received no later than 31 days prior to the original termination date. Contact the servicing agent for information. Payment for the entire term of continuation coverage must be selected and paid at the time of initial application.

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## **IMPORTANT FOR MONTHLY ENROLLEES**

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Monthly premium payment is available for Policy Year coverage, but on an AUTOMATIC DEBIT basis only. Students who elect monthly payment, whose coverage lapses (because of insufficient funds) during the Policy Year, WILL NOT be permitted to continue the monthly payment option, and will be required to wait until the next open enrollment period to reapply for these benefits.

## SCHEDULE OF BENEFITS

### \$50,000 Maximum Lifetime Benefit Per Injury or Sickness

In Network Deductible: \$250 – Out of Network: \$500

Family Annual Deductible: In Network: \$500 – Out of Network: \$1,000

## COVERED MEDICAL EXPENSES

	PPO Allowances	Another Provider/ R&C
<b>Inpatient Hospital Services:</b> Room & Board including intensive care up to \$1200 per day .....	80%	60%
<b>Outpatient Hospital Services including Emergency Accident and Sickness Care:</b> Reasonable & Customary Charges subject to a \$100 co-pay per emergency room visit. (see definition of 'Medical Emergency' on page 11) .....	80%	60%
<b>Hospital Miscellaneous Charges</b> .....	80%	60%
<b>Pre-Admission Testing:</b> Paid under Hospital Miscellaneous Benefit .....	80%	60%
<b>Surgical/Medical Services:</b> Reasonable & Customary charges for Surgery, Obstetrical, Outpatient Surgery, Medical Services, Multiple Surgical Procedures through the same incision, we will pay an amount not less than that for the most expensive procedure being performed. ...	80%	60%
<b>Anesthesia Expense:</b> 25% of Surgical Allowance .....	n/a	n/a
<b>Assistant Surgeon Expense:</b> 25% of Paid Surgical Expense .....	n/a	n/a
<b>Outpatient Diagnostic Services:</b> Reasonable & Customary charges for Radiology, Ultrasound and Nuclear Medicine, Laboratory and Pathology, ECG, EEF and other Electronic Diagnostic Medical Procedures, \$20 co-pay per visit not to exceed \$500 per Injury or Sickness ...	80%	60%
<b>Home Health Care:</b> At least a maximum number of 40 visits per calendar year; \$50 Deductible, not to exceed \$300 per Policy Year .....	80%	60%
<b>Outpatient Doctor's Visit:</b> \$25 co-pay per visit .....	80%	60%
<b>Chiropractic Care:</b> \$25 co-pay per visit, not to exceed \$1,000 per Policy Year. ....	80%	60%
<b>Outpatient Physical/Occupational therapy:</b> \$25 co-pay per visit, not to exceed \$1,000 per Policy Year .....	80%	60%
<b>Prescription Medication:</b> \$15 co-pay generic; \$30 co-pay brand name, not to exceed \$500 for the Policy Year (submit receipts to company for reimbursement) .....	n/a	80%

<b>Mental and Nervous Conditions</b> .....	80%	60%
<b>Inpatient:</b> Up to 30 days of hospital confinement per Policy Year.		
<b>Outpatient:</b> \$50 per day for Individual Therapy; \$25 per day for Group Therapy; not to exceed a maximum benefit of 30 days per Policy Year.		
<b>Alcohol and Chemical Dependency:</b> \$500 maximum per Policy Year. ....	80%	60%
<b>Ambulance Service:</b> \$1,000 maximum per Injury or Sickness .....	80%	60%
<b>Licensed Nurse Expense</b> .....	80%	60%
<b>Dental Services:</b> Accidental Injury, only to sound, natural teeth up to \$100 per tooth .....	80%	60%
<b>Durable Medical Equipment and Prosthetic Appliances:</b> \$200 maximum per Policy Year .....	80%	60%
<b>Cytologic Screening (PAP Smear)</b> .....	80%	60%
<b>Diabetes Treatment</b> .....	80%	60%
<b>Consultant Physician:</b> \$25 co-pay .....	80%	60%
<b>Chemotherapy and Radiation</b> .....	80%	60%
<b>Injections</b> .....	80%	60%
<b>Maternity Care Services and Complications of Pregnancy</b> .....	80%	60%

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## DESCRIPTION OF BENEFITS

### PERCENTAGE OF COVERED EXPENSES PAYABLE AND BEECH STREET PREFERRED PROVIDER NETWORK

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Persons insured under this plan may choose to be treated within, or out of, the Beech Street Preferred Provider Network. The Beech Street Preferred Provider Network consists of Hospitals, Doctors, and other health care providers who have contracted to provide specific medical care at negotiated prices. Reimbursement rates will vary according to the source of care, as described under the Description of Benefits herein.

In order to use the services of a participating provider, you must present your identification card. Your permanent I.D. Card is available through the Student Insurance website at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).

You should always confirm that a Preferred Provider is participating at the time services are rendered (by asking the provider when you make an appointment for service).

A complete listing of Beech Street participating providers is available on the web at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com) or you may call them at (800) 432-1776.

**When an Insured Person uses the services of a Beech Street Preferred Provider, the Covered Expenses incurred will be payable at 80% of the Preferred Allowance after the Deductible has been met. However, when treatment is rendered by providers outside the Beech Street Preferred Provider Network, Expenses will be payable at 60% of Reasonable and Customary charges after the Deductible has been met.**

Assignment of a network Doctor does not guarantee eligibility or the right to Student Health Benefits.

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## ADDITIONAL MANDATED BENEFITS

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The State of Texas mandates coverage for the following benefits: mammograms; treatment of diabetes, equipment, supplies and outpatient self-management training for the Insured Person and caretaker; formulas necessary for the treatment of phenylketonuria or other heritable diseases; temporomandibular and craniomandibular joint dysfunction; childhood immunizations (not subject to the deductible or coinsurance); minimum 48 hours hospital stay following mastectomy including initial prosthetic device and reconstructive surgery; prostate cancer screening; screening test for hearing impairment from birth to 30 days old and necessary diagnostic follow-up care through 24 months old (not subject to the deductible); telemedicine and telehealth services; reconstructive surgery for an Insured Person under age 18 to create a normal appearance; colorectal cancer screening; treatment of mental or nervous disorders in a crisis stabilization unit or residential treatment center for a Dependent child, the same as if treatment were provided in a hospital; minimum 24 hours hospital stay following a lymph node dissection for treatment of breast cancer; bone mass measurement for the detection of low bone mass in an osteoporosis qualified individual; and therapies and services as a result of and related to an acquired brain injury. Please see the Policy at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).

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## PRE-EXISTING CONDITIONS

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**“Pre-existing Condition”** is a Sickness, Injury, or related condition for which a licensed Doctor was consulted; or for which treatment or medication was prescribed within twelve (12) months prior to the Effective Date of the Insured Person’s coverage under this Policy.

The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Student’s effective date, and b) We will pay only for Loss or expense incurred after such twelve (12) consecutive month period.

This limitation will not apply, if during the period immediately preceding the Insured Person’s effective date of coverage under the Policy or, the Insured Person was covered under the Policy, the period immediately preceding the Insured Person’s effective date of coverage under the Policy, the Insured Person was covered under prior creditable Coverage for an aggregate period of 18 months. The Insured Person shall be credited with the time prior creditable coverage was in effect at any time during the 18 months preceding the effective date of coverage.

A period of creditable coverage will be credited if the previous Creditable Coverage was continuous to a date not more than 63 days prior to the Effective date of the new coverage.

**Creditable Coverage means coverage under any of the following:**

- a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.);
- b) a group health benefit plan provided by a health insurance carrier or health maintenance organization;
- c) an individual health insurance policy or evidence of coverage;
- d) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.);
- e) Title XIX of the Social Security Act (U.S.C. 1396 et seq.), other than coverage solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s);
- f) Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.);
- g) a medical care program of the Indian Health Service or of a tribal organization;
- h) a state health benefits risk pool;
- i) a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.);
- j) A public health plan. A public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in this plan, as defined in 45 C.F.R. Sec. 146.113, authorized by the Public Services Act, 42 U.S.C. Sec. 300 gg(c)(1)(l);

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## PRE-EXISTING CONDITIONS (CONTINUED)

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- k) a health benefit plan under section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e))
- l) any other creditable coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec 300gg (c)).

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## MEDICAL EVACUATION / REPATRIATION FOR INTERNATIONAL AND STUDY ABROAD STUDENTS

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**MEDICAL EVACUATION:** If an Insured Person sustains an Injury or suffers a sudden Sickness while traveling outside his/her Home Country, the Insurer will pay the Medically Necessary expenses incurred, up to \$10,000, for a medical evacuation to the nearest Hospital, appropriate medical facility or back to the Insured Person's Home Country. Transportation must be by the most direct and economical route. However, before the Insurer makes any payment, it requires written certification by the attending Doctor that the evacuation is Medically Necessary. Any expenses for medical evacuation require the Insurer's or the Administrator's prior approval.

**REPATRIATION OF REMAINS (for International & Study Abroad Students Only):** If a Covered Person dies, the Insurer will pay the necessary expenses actually incurred, up to \$7,500, for the repatriation of the Covered Person's remains to his/her place of residence in their Home Country. This benefit covers the legal minimum requirements for the transportation of the remains. It does not include the transportation of anyone accompanying the body or visitation or funeral expenses. Any expenses for Repatriation of Remains require the Insurer's or the Administrator's prior approval.

**TRAVEL ASSISTANCE SERVICES:** Included in this health insurance program is access to a 24-hour worldwide assistance network for emergency assistance anywhere in the world. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriations.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:

Toll Free from U.S. and Canada: 1-800-850-4556; Outside of the U.S. and Canada please call collect.

[www.oncallinternational.com](http://www.oncallinternational.com)

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## ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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When because of an Injury, the Insured Person suffers any of the following Losses within 365 days from the date of the Accident, We will pay as follows:

<b>For Loss of:</b>	<b>Amount</b>
Life .....	\$5,000
Both hands or both feet or sight of both eyes .....	\$5,000
One hand and one foot .....	\$5,000
One hand and sight of one eye .....	\$5,000
One foot and sight of one eye .....	\$5,000
One hand or one foot or sight of one eye .....	\$2,500
Thumb and Index Finger of Either hand .....	\$1,250

Loss of hands and feet means the loss at or above the wrist or ankle joints. Loss of eyes means total irrecoverable loss of the entire sight. Loss with regards to thumb and index finger means severance through or above metacarpophalangeal joints.

Only one of the amounts named above will be paid for Injuries resulting from any one Accident. The amount so paid shall be the largest amount that applies. This provision does not cover the Loss if it in anyway results from:

- (1) Suicide, attempted suicide, or intentionally self-inflicted Injury;
- (2) Physical or mental illness; medical or surgical treatment except treatment that results directly from a surgical operation made necessary solely by an Injury covered by the Policy;
- (3) An infection, unless it is caused solely and independently by a covered Accident;
- (4) Expenses for which a contributing cause was the Insured Person's commission of, or attempt to commit a felony, or for which an Insured Person's engagement in an illegal occupation was the contributing cause; or
- (5) The Insured Person being legally intoxicated or under the influence of any drug unless taken as prescribed by a Doctor. In addition to the above, the provision is subject to the Exclusions as provided.

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## DEFINITIONS

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**"Accident"** means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

**"Coinsurance"** means the percentage of Reasonable and Customary Expenses for which Insured Person is responsible for a covered service.

**"Covered Charge"** or **"Expense"** as used herein means those charges for any treatment, services, or supplies that are: a) for Network Providers, not in excess of the Preferred Allowance; b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; c) not in excess of the charges that would have been made in the absence of this insurance except for institutions, controlled or owned by state and/or local governments, which provide services to indigent and non-indigent patients; and d) incurred while this Policy is in force as to the Insured Person except with respect to any expense payable under the Extension of Benefits Provision.

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## DEFINITIONS (CONTINUED)

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**“Deductible”** means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

**“Doctor”** as used herein means: a) a legally qualified Doctor licensed by the state in which he or she practices; or b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or c) a certified nurse midwife while acting within the scope of the certification.

**“Domestic Student”** is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

**“Elective Treatment”** means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person’s Effective Date of coverage. Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; infertility; complications arising from cosmetic surgery; circumcision; bunions; hammertoes; and impacted toenails. Elective Treatment includes breast reduction and breast implants except for breast reconstruction following a mastectomy as provided for in the Breast Reconstruction Expense Benefit. Elective Treatment includes immunizations except for childhood immunizations as provided for in the Childhood Immunizations Expense Benefit.

**“Experimental or Investigational Care”** means a service or supply; a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis/treatment; or b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

**“Home Country”** means the country from which the Insured Person holds a passport. Where the Insured Person holds more than one passport, the Home Country will be the country that the Insured Person has declared with the Company.

**“Hospital”** means a facility which meets all of these tests:

a) it provides inpatient services for the care and treatment of injured and sick people; and b) it provides room and board services and nursing services 24 hours a day; and c) it has established facilities for diagnosis and major surgery (except for a mental institution that contracts with a Hospital for major surgery); and d) it is supervised by a Doctor; and e) it is run as a Hospital under the laws of the jurisdiction in which it is located. Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

**“Hospital Confinement”** means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

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## DEFINITIONS (CONTINUED)

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**“Injury”** means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

**“Insured Person”** means an Insured Student and his or her covered Dependent(s) while insured under this Plan.

**“Insured Student”** means a student of the Policyholder who is eligible and insured for coverage under this Plan.

**“International Student”** is a student classified as a Non-Immigrant. For example, students holding visa types: “F” (Student), “J” (Exchange Visitor), “B” (Tourist), or “A” (Diplomat).

**“Loss”** means medical expense covered by this Policy as result of Injury or Sickness as defined in this Policy and other expenses as specifically covered.

**“Medical Emergency”** means the unexpected onset of an Injury or Sickness which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: a) placing the health of the individual in serious jeopardy; b) serious impairment to bodily functions; c) serious dysfunction of any bodily organ or part; d) serious disfigurement; or e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

**A Medical Emergency does not include elective or routine care.**

**“Medically Necessary”** a service or supply is necessary and appropriate for the diagnosis or treatment of a Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if: a) it is provided only as a convenience to the Insured Person or provider; b) it is not the appropriate treatment for the Insured Person’s diagnosis or symptoms; or c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment. The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**“Network Providers”** are Doctors, Hospitals, and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

**“Non-network Providers”** have not agreed to any pre-arranged fee schedules.

**“Preferred Allowance”** means the amount a Network Provider will accept as payment in full for Covered Charges.

**“Reasonable and Customary Expenses”** means fees and prices generally charged within the locality where performed, for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

**“Sickness”** means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or related cause are considered one Sickness.

**“We”, “Us”, and “Our”** mean the Combined Insurance Company of America.

**“You” and “Your”** mean the Insured Person.

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## **DETERMINING REASONABLE EXPENSES**

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Expenses incurred within the PPO Network are based upon negotiated fee schedules with providers. Reasonable Expenses incurred outside of the PPO Network will be based on the Ingenix survey of prevailing fees, valued at the 70th percentile, in the area where the service is provided.

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## **SUBROGATION**

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If We pay Covered Expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid. We may also take subrogation action directly against the third party. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights under this provision and do nothing to prejudice Our rights.

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## **EXCLUSIONS AND LIMITATIONS**

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Unless specifically provided for elsewhere under the Policy, the Policy does not cover loss caused by, or resulting from, nor is any premium charged for, any of the following:

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Organ transplants, except as specifically provided;
4. Pre-existing Conditions as defined in this Policy;
5. Nonprescription drugs or medicines, except for insulin;
6. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
7. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with inter-scholastic sports, intercollegiate sports, intercollegiate club sports, and professional sports;
8. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved body part, reconstructive surgery because of congenital disease or anomaly of a covered Dependent newborn child;
9. Illness, Accident, treatment, or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, bungee jumping, parachuting or bungi-cord jumping;
10. Correction of congenital defects except as specifically provided;

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## **EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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11. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
12. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;
13. Expense incurred after the date insurance terminated for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
14. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
15. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
16. Injury due to participation in a riot;
17. Charges for which Insured Person's have no legal obligation to pay in absence of this or like coverage;
18. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brother, and sisters.
19. Personal hygiene/convenience items; telephone consultations, missed appointments, photocopies or medical records, or completion of claim forms; expenses incurred for custodial care or services not needed to diagnose or treat an Injury or Sickness, including but not limited to services related to the activities of daily living;
20. Expenses incurred in connection with family planning, the enhancement of fertility, fertility tests, correction of infertility, artificial insemination, and services or supplies for inducing conception;
21. Expenses incurred in connection with a voluntary sterilization procedure or any sterilization reversal process;
22. Expense incurred for eye examinations, or prescriptions, eye glasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), including eye refractions, vision therapy, multiphasic testing, radial keratotomy, hearing aids, or supplies related thereto or Lasik or other vision procedures except as required for repair caused by a covered Injury;
23. Routine periodical physical examinations and routine chest x-rays, except as specifically provided;
24. Treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
25. An amount of a charge in excess of the Reasonable and Customary Expense;
26. Elective Treatment or elective surgery, except as specifically provided;

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**EXCLUSIONS AND LIMITATIONS (CONTINUED)**

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27. Services not Medically Necessary;
28. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
29. Treatment of mental or nervous disorders except as specifically provided;
30. Treatment of alcohol and substance abuse except as specifically provided;
31. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
32. Expense incurred for: tubal ligation; vasectomy; breast implants; breast implant removal; breast reduction; sexual reassignment surgery; impotence (organic or otherwise); non-prescription birth control; submucous resection and/or other surgical correction for deviated nasal septum, other than for required treatment of acute purulent sinusitis; circumcision; gynecomastia; hirsutism;
33. Medicines not taken in the dosage or for the purpose prescribed by the Insured Person's Doctor;
34. Expenses incurred for any experimental drug or drug combination which the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug which the FDA has determined to be contraindicated for a particular condition;
35. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;

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**COORDINATION OF BENEFITS**

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The Policy will coordinate benefits as outlined in the Master Policy.

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## CONTINUOUS INSURANCE

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Persons who have remained continuously insured under the Policy, and have prior creditable coverage, will be covered for a Pre-existing Condition that originated while so continuously insured, provided continuous insurance is maintained.

Previously Insured persons who are re-enrolled for coverage within 63 days of termination of prior coverage, will have maintained continuous coverage. A person who is not so re-enrolled will have a break in continuous insurance and will not be covered for any Pre-existing Condition that originated before or during such break.

The total benefits payable under the Policy, for any one Injury or Sickness, shall not exceed the "specified" Maximum Benefit amounts.

**"Prior Plan"** means the group or blanket accident and sickness Student Health Insurance policy or policies issued to the Policyholder immediately before the current Policy.

**"Injury"** or **"Sickness"** shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

No Benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Previously insured Eligible Students and Dependents must re-enroll for coverage within 30 days of the end of the prior coverage in order to avoid a break in the coverage for conditions which existed in prior Policy Years. Nothing contained herein shall be held to vary, alter, waive, or extend any of the provisions, exclusions, and other terms of this Policy, except as provided above.

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## COMPLAINT RESOLUTION

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Insured Persons, Preferred Providers, Non-Preferred Providers, or their representatives with questions or complaints, may call the Customer Service Department at (800) 452-5772. If the question or complaint is not resolved to the satisfaction of the complainant, the complainant may submit a written request to the Claims Review Committee, which will make a thorough investigation and respond to the complainant in a timely manner. The Company will not retaliate against the complainant because of the complaint.

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## HOW DO I ENROLL IN THE STUDENT HEALTH INSURANCE PROGRAM?

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1. You may enroll via the Internet at: [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com) using an electronic check or major credit card.
2. You may complete the attached application, along with your credit card number and expiration date, or you may include a check/money order made payable to:

**STUDENT INSURANCE PLAN  
POST OFFICE BOX 189  
LIBERTYVILLE, ILLINOIS 60048**

3. You may call us at (800) 452-5772 and pay by phone.

***We accept American Express, Discover, Mastercard, and Visa credit cards, as well as your personal check.***

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## HOW DO I OBTAIN MY IDENTIFICATION CARD?

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1. You may detach and retain the temporary Identification Card provided on the brochure.
2. You may obtain your permanent Identification Card on the Internet at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com). Click on "Print ID Card". You will need to provide your name, student identification number, and your birth date. If you experience any difficulty, please call us at (800) 452-5772.
3. You may call (800) 452-5772 and request that your permanent Identification Card be mailed to you.

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## HOW DO I FILE MY CLAIM UNDER THE STUDENT INSURANCE PROGRAM?

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1. Secure the necessary medical treatment. A listing of Preferred Providers is available at: [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)
2. Obtain itemized bills from your Doctor or provider.
3. Complete a claim form. A claim form is available at:  
[www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)

If your provider has already mailed the bills to the Insurance Company, you may complete the claim form and email it to the Insurance Company. If you have not yet mailed the medical bills to the Insurance Company, print a claim form, complete it, and mail the completed claim form along with your medical bills to the Insurance Company at:

**Administrative Concepts, Inc.**  
**994 Old Eagle School Road, Suite 1005**  
**Wayne, PA 19087-1802**  
**(800) 452-5772**

Written notice of claim must be given within 30 days after the occurrence, or commencement of any loss covered by the Policy. Bills for which benefit is to be paid must be submitted within 90 days of the date of treatment.

4. Any additional medical bills submitted for reimbursement by the Insurance Company must show your name, student identification number, name of college or university, and description of medical condition.  
**Only one claim form, per condition, needs to be completed.**
5. Online claim inquiry is available through the student insurance website [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).

**You may check the status of a claim you have already filed at: [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com) and click "Check Claims Online". (If you experience difficulty retrieving your records please call 800-452-5772.)**

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## HOW CAN I RECEIVE ASSISTANCE WITH A QUESTION OR PROBLEM?

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Please call the Administrator, at (800) 452-5772, Monday through Friday, between the hours of 7:00 a.m. to 7:00 p.m. Central Time, or email us: [office@aipinternational.com](mailto:office@aipinternational.com). We appreciate hearing from you with your comments, questions, and concerns.

Any provision of the Policy, or the brochure, which is in conflict with the statutes of the state in which the Policy is issued, will be administered to conform with the requirements of the state statutes.

Please keep this brochure as a general summary of the insurance. The Master Policy contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between the brochure and the Policy, the Master Policy will govern and control the payment of benefits. This brochure is based on Policy CUH 201571.

Your representative in Texas:  
**Mr. Allan Dunlap**  
**Dunlap Financial Services**  
**111 East University Drive, Suite 110**  
**College Station, Texas 77841**  
**(979) 260-9632**

\* \* \* \* \*

Medical Benefits Underwritten by:



Claims should be mailed to:  
**Administrative Concepts, Inc.**  
**994 Old Eagle School Road, Suite 1005**  
**Wayne, PA 19087-1802**  
**(800) 452-5772**

\* \* \* \* \*

Direct all inquiries to:



**ASSOCIATED**  
**INSURANCE PLANS**  
INTERNATIONAL, INC.

Post Office Box 189  
Libertyville, Illinois 60048  
**(800) 452-5772 • FAX (847) 281-8813**  
(e-mail) [office@AIPInternational.com](mailto:office@AIPInternational.com)

Visit us and enroll on the Web at: [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)

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## **NOTICE OF PRIVACY PRACTICE**

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This describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully at: [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)

## OPTIONAL - ADDITIONAL PREMIUM REQUIRED DENTAL/VISION/PHARMACY DISCOUNT PLAN

Additional premium required (see rates listed on following page).

- No Claim forms
- No Waiting Periods
- No Pre-existing Conditions
- No Deductibles or Maximums
- No Age Restriction
- Discount is immediate at time of service
- Over 100,000 participating providers nationwide

The Co-Health Group Collegiate plan has been specifically designed to meet the needs of today's College and University students, whether they are incoming freshmen, graduate, evening students, international or domestic students attending Austin Community College.

The Co-Health Benefit Plan provides discounts in certain health care areas not normally reimbursed by insurance. In the "Collegiate Plan" we are offering the Vision, Dental and Pharmacy Discount Program as a single package of Benefits, or you may purchase discounts for pharmacy or vision separately. Here's how the plan works.

This is not an Insurance Plan. The Co-Health Group Collegiate Plan is a Discount Care Plan offering discounts and savings for Vision, Dental and Prescription Pharmacy expenses.

Each of the benefit programs (Vision, Dental, and Prescription Pharmacy) has a network of Providers (for example, the participating dentists in the Dental Plan.) As a member of the Plan you can go to any of the providers listed and purchase their products or services on a negotiated discount basis. You receive your discount/savings on the spot. There are no exclusions for "pre-existing" conditions. There are no claim forms to fill out and no paperwork to be filed. Simply show your Co-Health membership card at the time of your scheduled appointment or at a participating pharmacy.

The discounts you will receive are substantial and these savings can be very important to you. The services that make up the Collegiate Plan (Vision, Dental and Pharmacy) are also the three most common areas where you will have unexpected expenses. With our Benefits, you can substantially reduce your out of pocket expenses, and as an added bonus, you can use our plan benefits anywhere in the United States, except the State of Washington.

You simply show your Co-Health ID Card and get your discount on the spot.

**Annual Coverage Premiums - enroll anytime throughout the year at [www.AustinCCInsurance.com](http://www.AustinCCInsurance.com).**

<b>ANNUAL PREMIUMS Dental/Vision/Pharmacy</b>	<b>Credit Card or Internet Payment</b>	<b>Check by mail</b>
Student Only	\$72.00	\$62.00
Family	\$98.00	\$88.00
<b>Vision &amp; Pharmacy</b>		
Student Only	\$50.00	\$40.00
Family	\$71.00	\$61.00
<b>Vision</b>		
Student Only	\$25.00	\$15.00
Family	\$30.00	\$20.00
<b>Pharmacy</b>		
Student Only	\$25.00	\$15.00
Family	\$30.00	\$20.00

# Yes,

I wish to participate in the Student Health Insurance Plan. My check or money order payable to Student Insurance Plan for the coverage indicated below is enclosed.

Annual 08-25-08 to 08-24-09	
Student Only	<input type="checkbox"/> \$ 1,936
Student & Spouse	<input type="checkbox"/> \$ 5,358
Student & Children	<input type="checkbox"/> \$ 7,539
Student, Spouse & Children	<input type="checkbox"/> \$11,059

*One Semester Fall, 08-25-08 to 1-19-09 Spring, 01-20-09 to 05-31-09	
Student Only	<input type="checkbox"/> \$ 698
Student & Spouse	<input type="checkbox"/> \$1,929
Student & Children	<input type="checkbox"/> \$2,713
Student, Spouse & Children	<input type="checkbox"/> \$3,981

*Spring and Summer 01-20-09 to 08-24-09	
Student Only	<input type="checkbox"/> \$1,240
Student & Spouse	<input type="checkbox"/> \$3,429
Student & Children	<input type="checkbox"/> \$4,824
Student, Spouse & Children	<input type="checkbox"/> \$7,062

*Summer or **Quarterly 06-01-09 to 08-24-09	
Student Only	<input type="checkbox"/> \$ 533
Student & Spouse	<input type="checkbox"/> \$1,457
Student & Children	<input type="checkbox"/> \$2,046
Student, Spouse & Children	<input type="checkbox"/> \$2,996

\*\*See Quarterly Terms outlined on page 2.

Summer Semester I 06-01-09 to 07-07-09	
Student Only	<input type="checkbox"/> \$ 172
Student & Spouse	<input type="checkbox"/> \$ 457
Student & Children	<input type="checkbox"/> \$ 639
Student, Spouse & Children	<input type="checkbox"/> \$ 932

Summer Semester II 07-08-09 to 08-24-09	
Student Only	<input type="checkbox"/> \$ 344
Student & Spouse	<input type="checkbox"/> \$ 914
Student & Children	<input type="checkbox"/> \$1,278
Student, Spouse & Children	<input type="checkbox"/> \$1,864

Monthly AUTOMATIC DEBIT ONLY (debited on the 25th of each month through July 25, 2009)	
Student Only	<input type="checkbox"/> \$172
Student & Spouse	<input type="checkbox"/> \$457
Student & Children	<input type="checkbox"/> \$639
Student, Spouse & Children	<input type="checkbox"/> \$932

\*NOTE: Renewal premium notices for terms other than monthly, will be mailed to the address provided, however, it is your responsibility to submit premium prior to expiration date in order to avoid a lapse in coverage.



[www.AustinCCInsurance.com](http://www.AustinCCInsurance.com)

# AUSTIN COMMUNITY COLLEGE • STUDENT INSURANCE AUTOMATIC PAYMENT AUTHORIZATION 2008-2009

I request and authorize STUDENT INSURANCE PLAN and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account.

DRAFT DATE: \_\_\_\_\_ (Will be debited on the 25th of each month) DRAFT AMOUNT: \_\_\_\_\_ Check One:  Checking Account  Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED \_\_\_\_\_

ADDRESS OF BANK \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_

NAME OF INSURED, APPLICANT (PRINT) \_\_\_\_\_ NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED \_\_\_\_\_

DEPOSITOR SOCIAL SECURITY NUMBER \_\_\_\_\_ DEPOSITOR DRIVERS LICENSE NUMBER \_\_\_\_\_ DEPOSITOR STATE \_\_\_\_\_ RELATIONSHIP TO INSURED \_\_\_\_\_

SIGNATURE OF DEPOSITOR \_\_\_\_\_ DATE \_\_\_\_\_

AUTOMATIC PAYMENT FROM YOUR CHECKING ACCOUNT REQUIRES A COPY OF A VOIDED CHECK (PLEASE DO NOT SEND A DEPOSIT SLIP) (Premiums will be charged on the date due as specified in the brochure)

Please charge my credit card a one time payment of: \_\_\_\_\_  Please automatically charge my Student Insurance premiums to my credit card for this entire policy year. (Premiums will be charged on the date due as specified in the brochure)

VISA  DISCOVER  MASTERCARD  AMEX

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Last 3 numbers on the reverse side of the credit card. Located within the signature box. \_\_\_\_\_ (For Authorization Purpose)

Print name of cardholder \_\_\_\_\_ Cardholder phone number \_\_\_\_\_

Amount authorized to debit \_\_\_\_\_ for Student Health Insurance. Cardholder signature \_\_\_\_\_ Today's Date \_\_\_\_\_

FOR HOME OFFICE USE ONLY BANK TRANSIT NUMBER \_\_\_\_\_ DEPOSITOR'S ACCOUNT NUMBER \_\_\_\_\_

# AUSTIN COMMUNITY COLLEGE • STUDENT ENROLLMENT CARD 2008-2009

Please Print Legibly

Student's name \_\_\_\_\_ (First) \_\_\_\_\_ (M) \_\_\_\_\_ (Last) \_\_\_\_\_ Student I.D. # \_\_\_\_\_ Social Security # \_\_\_\_\_

Billing Address \_\_\_\_\_ (Street) \_\_\_\_\_ (Apt.#) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_\_ Telephone No. \_\_\_\_\_ Alternate Telephone No. \_\_\_\_\_

Do you have any other medical insurance?  YES  NO. If yes name of insurance company. \_\_\_\_\_

E-mail Address (IMPORTANT!) \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Child \_\_\_\_\_ Child \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth (mm/dd/yy) \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_ Date of Birth (mm/dd/yy) \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

I have carefully read the brochure and elect to enroll as indicated. Rates are not pro-rated other than as listed. PLEASE MAKE SURE TO INDICATE COVERAGE DESIRED  
My remittance in the amount of \$ \_\_\_\_\_ is enclosed.

Check here if you are an International Student. Type of Visa \_\_\_\_\_ Home Country \_\_\_\_\_

MONTHLY ENROLLEES ••••• Please indicate which month you desire your coverage to begin \_\_\_\_\_ (Month) **Monthly enrollees must complete Automatic Payment Authorization Form**

QUARTERLY ENROLLEES ••• Please indicate which quarter you desire your coverage to begin  Aug. 25th  Nov. 25th  Feb. 25th  May 25th

Make check or money order payable to Student Insurance Plan. Mail this enrollment card along with premium to: Post Office Box 189, Libertyville, IL 60048

Please charge my Student Health Insurance: **You must re-enroll in the insurance plan each term other than annually.**

VISA  DISCOVER Card Number \_\_\_\_\_ 3 or 4 digit security code \_\_\_\_\_ Expiration Date \_\_\_\_\_

MASTERCARD  AMEX Print name of cardholder \_\_\_\_\_ Cardholder signature \_\_\_\_\_

Please Charge \$ \_\_\_\_\_ for Student Health Insurance. Student signature \_\_\_\_\_

NOTE: You may enroll "On-line" and pay your premium by electronic check or major credit card at [www.AustinCInsurance.com](http://www.AustinCInsurance.com)