

# J1 Exchange Plans

## J1 VISA ACCIDENT & SICKNESS INSURANCE PLANS



Meets and exceeds the **new J1 visa** requirements of the U.S. Department of State

ISO16LUJEX



(800) 244-1180

[www.isoa.org](http://www.isoa.org)

# J1 Exchange Visitors Health Insurance Plans

ISO is proud to offer you **J1 Exchange Visitors Health Insurance Plans**. **J1 Exchange Visitors Plans** are accident and sickness insurance plans, designed to meet the particular needs of J1 visa exchange visitors who are currently studying in the USA. You must be outside your home country/country of permanent residence to receive the benefits of coverage.

## Summary Schedule of Benefits

Benefits	J1 Exchange LF003236	J1 Exchange Superior LF003237
Medical expense benefits <sup>1</sup>	\$125,000	\$300,000
Lifetime medical maximum	No maximum	No maximum
Deductible	\$400 <sup>1</sup>	\$250 <sup>1</sup>
Co-insurance in-network	75% of preferred allowance	75% of preferred allowance
Co-insurance out-of-network	75% of usual reasonable & customary charge	75% of usual reasonable & customary charge
Emergency room co-pay (waived if admitted)	\$250	\$250
Hospitalization co-pay	\$250	\$250
Maternity	Covered <sup>2</sup>	Covered <sup>2</sup>
Pre-existing conditions	Covered after 6 months	Covered after 6 months
Medical evacuation/repatriation	\$50,000	\$60,000
Repatriation of remains	\$25,000	\$50,000

<sup>1</sup> Per injury or sickness

<sup>2</sup> Conception must occur while coverage is in effect

## Monthly Rate

Age	J1 Exchange	J1 Exchange Superior
12 - 65	\$39	\$58
Child	\$96	\$137
Spouse	\$253	\$361

# Medical Expense Benefits

We will pay benefits for **covered expenses** incurred by a plan participant for loss due to **sickness** or **injury**, subject to the maximum benefit for all services as shown in the Schedule after the **deductible** and any required **co-insurance** and/or **co-payment** are satisfied.

**Covered expenses** are considered incurred when the covered service is rendered, provided there is a charge made for such service.

We provide payment for services, procedures and supplies that are **medically necessary**. No benefits will be paid for expenses determined not to be medically necessary, including any or all days of **hospital stay**.

The total payable for all **covered expenses** will not exceed the maximum benefit shown in the schedule. Also read the DEFINITIONS section carefully. No benefits will be paid for services designated as "No Benefits" in the schedule.

## Inpatient Covered Expenses include:

### 1. Hospital Services:

#### Room and Board Expense:

- a. Daily semi-private room rate for a hospital stay; and
- b. General nursing care provided and charged for by the hospital.

#### Intensive Care

#### Physiotherapy

#### Miscellaneous Expenses:

- a. During a hospital stay; or
- b. As a precondition for a hospital stay.

Benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies.

### 2. Surgery Services:

#### Surgeon

#### Assistant Surgeon

#### Anesthetist

#### Nurses:

- a. Private duty nursing care only;
- b. During a **hospital stay**;
- c. Ordered by a **physician** and
- d. **Medically necessary**.

General nursing care provided by the **hospital** is not covered under this benefit.

**3. Physician's Visits** during a **hospital stay**. Benefits are limited to one visit per day. Benefits do not apply when related to surgery.

**4. Preadmission Testing** limited to routine tests such as: complete blood count; urinalysis; and chest X-rays. If otherwise payable under the policy, major diagnostic procedures such as: cat-scans; NMR's; and blood chemistries will be paid under the hospital miscellaneous expenses benefit.

**5. Psychotherapy** for the treatment of a mental or emotional disorder or of related bodily illness by psychological means where the psychotherapy is administered by a physician.

## Outpatient Medical Expenses Include:

### 1. Surgery Services:

**Surgeon**

**Anaesthetist**

**Miscellaneous for Day Surgery** benefits will be paid for services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anaesthesia; drugs or medicine; therapeutic services; and supplies.

2. **Miscellaneous Hospital** and **Physician** services payable as shown in the Schedule.

3. **Physician's Visits** limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.

4. **Physiotherapy** limited to one visit per day.

5. **Medical Emergency** as defined. Benefits will be paid as shown in the Schedule.

6. **Diagnostic X-ray Services**

7. **Radiation Therapy**

8. **Laboratory Procedures**

9. **Tests and Procedures:**

- a. Diagnostic services and medical procedures;
- b. Performed by a physician;
- c. Excluding physician's visits; Physiotherapy; X-rays; and Laboratory Procedures.

10. **Injections:**

- a. When administered in the physician's office; and
- b. Charged on the physician's statement.

11. **Prescription Drugs**

12. **Chemotherapy**

## Other Services:

1. **Ambulance Services**

2. **Durable Medical Equipment - Braces and Appliances:**

- a. When prescribed by a **physician**; and
- b. When a written prescription accompanies the claim when submitted.  
Braces and appliances include durable medical equipment which:
  - Is primarily and customarily used to serve a medical purpose
  - Can withstand repeated use, and
  - Is not generally useful to a person in the absence of **sickness** or **injury**.No benefits will be paid for rental charges in excess of purchase price.

3. **Consulting Physician** when requested and approved by the attending **physician**. **Covered expenses** will be paid under this benefit or under the **physician's visits** benefit, but not both on the same day.

4. **Dental Treatment** performed by a physician and made necessary by **injury** to **natural** teeth.

5. **Prescription Drug Expenses** including dressings, drugs and medicines prescribed by a Physician and administered on an outpatient basis, payable at 75% of charges;
6. **Medical Services and Supplies:** expenses for blood and blood transfusions; oxygen and its administration;
7. **Mental and Nervous Disorder** (Outpatient);
8. **Mental and Nervous Disorders** (Inpatient);
9. **Therapeutic termination of pregnancy.**
10. **Maternity:** (conception must occur while this coverage is in effect)
11. **Alcoholism/Drug Abuse Treatment:** the benefits and the maximum amounts are the same as any Sickness;

**Coordination of Benefits Provision:** When a plan participant is covered under more than one valid and collectible insurance plan, benefits payable will be coordinated with the other plan. Reimbursement from all plans will never exceed 100%. A complete description of the coordination of benefits provision is included in the plan document on file with the plan manager.

**Conformity With State Statutes:** Any provision of the evidence of coverage which, on its effective date, is in conflict with the statutes of the state in which it is issued, is hereby amended to conform to the minimum requirements of such statutes.

## Medical Evacuation / Repatriation

Benefits will be paid for covered expenses up to the maximum stated in the summary schedule of benefits if an injury or sickness commencing during the period of coverage results in the necessary emergency evacuation of the plan participant. An emergency evacuation must be ordered by a legally licensed physician who certifies that the severity of the plan participant's injury or sickness warrants the emergency evacuation.

### **"Medical Evacuation" means:**

If the local attending legally qualified physician and the authorized travel assistance company determine that transportation to a hospital or medical facility or your return to your primary place of residence is medically necessary to treat an unforeseen sickness or injury which is acute or life threatening and adequate medical treatment is not available in the immediate area, the transportation expense incurred will be paid for the usual and customary charges for transportation to the closest hospital or medical facility capable of providing that treatment. All expenses must be authorized in writing or by an authorized electronic or telephonic means in advance. For authorization please contact On-Call International (866) 509-7715 or (603) 328-1728.

## Repatriation of Remains

In the event of the plan participant's death during a trip, the expense incurred within 30 days from the date of the covered loss will be paid for minimally necessary casket or air tray, preparation and transportation of the plan participant's remains to their home country/country of permanent residence.

All expenses must be authorized in writing or by an authorized electronic or telephonic means in advance. For authorization contact On-Call International (866) 509-7715 or (603) 328-1728.

## Eligibility

You are eligible if you are a participant of ISO – International Student Organization, are a non United States Citizen, have a current passport or visa, hold a J1 visa and are temporarily residing outside your home country/country of permanent residence, while actively engaged in education or research activities.

Your non-U.S. spouse and eligible dependent children are also eligible for coverage if accompanying you.

For purposes of this insurance, if your home country (passport country) is different from your country of permanent residence (location in which you permanently reside), you will not be covered in either location. Permanent residents or persons who have applied for permanent residency are not eligible for coverage under the master policy.

## Claim Procedure

In the event of sickness or injury, you should report to the student health services, if available, or the nearest physician or hospital. Persons insured under this plan may choose to be treated within or outside First Health or Multiplan networks. Reimbursement rates will vary according to the source of care as described under the summary schedule of benefits and medical expense benefits.

Please mail the completed claim form and accompanying documentation to the claims administrator: **HealthSmart, 3320 West Market Street, Suite 100, Fairlawn, OH 44333.**

The completed claim form, all itemized bills, statements and receipts must be sent to the claims administrator no more than 90 days after a covered loss occurs or end, or as soon after that as is reasonably possible.

Should it become necessary to check upon the status of your filed claim, you may call the claims administrator at (800) 331-1096 between 9:00 A.M. and 5:00 P.M. Monday through Friday or e-mail at **iso@healthsmart.com**. On line claims status via the internet is available 24 hours a day at **www.healthsmart.com**.

## Complaints

Complaints handling procedures are located at <https://www.isoa.org/faq>.

## Plan Manager: ISO

**If you have any questions please contact us at:  
(800) 244-1180 | [mailbox@isoa.org](mailto:mailbox@isoa.org) | [www.isoa.org](http://www.isoa.org)  
ISO representatives are here to assist you!**



## Period of Coverage

Coverage will begin at 12:01 am on the latest of the following:

- a. The effective date of the policy; or
- b. The date the enrollment form and premium are received by the underwriting company or its designated representative; or
- c. The date requested on the enrollment form; or
- d. The date the participant enters the United States.

Coverage will terminate at the earliest of the following:

- a. The last date for which premium has been paid; or
- b. The date the plan participant returns to his home country and is no longer eligible; or
- c. The date of entry into active duty military service.

### Extension Of Accident and Sickness Insurance Benefits

If Plan Participant is hospital confined at termination of coverage, benefits will continue to be paid until the earlier of either discharge from the hospital they are confined to or until the maximum benefit has been paid, whichever occurs first. In no event will benefits continue beyond 30 days beyond the term of coverage.

**Newborn Children Coverage:** Coverage for a newborn Child will begin from the moment of birth. You must give Us notice within 31 days of the birth of the Child. If notice is not given within 31 days, coverage for the newborn Child will terminate upon the expiration of the initial 31 day period.

## Exclusions

**The policy does not cover any loss resulting from any of the following unless otherwise covered under the policy by additional benefits:**

1. Suicide, attempted suicide (including drug overdose) self-destruction, attempted self-destruction or intentional self-inflicted Injury while sane or insane;
2. War or any act of war, declared or undeclared;
3. Voluntary, active participation in a riot or insurrection;
4. Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other and collectible insurance;
5. Organ transplants;
6. Treatment for an injury or sickness caused by, contributed to or resulting from the plan participant's voluntary use of alcohol, illegal drugs or any drugs or medication that is intentionally not taken in the dosage recommended by the manufacturer or for the purpose prescribed by the plan participant's physician;
7. Eligible expenses for which the plan participant would not be responsible in the absence of the policy;
8. Treatment of acne;
9. Charges which are in excess of usual, reasonable and customary charges;
10. Charges that are not medically necessary;
11. Charges provided at no cost to the plan participant;
12. Expenses incurred for treatment while in your home country, excess of \$500;
13. Regular health checkups, immunizations, vaccinations, routine physical, or other examination where there are no objective indications or impairment in normal health;
14. Services or treatment rendered by an immediate family member of the plan participant;

## Exclusions (continued)

15. Benefits for enrolling solely for the purpose of obtaining medical treatment, while on a waiting list for a specific treatment, or while traveling against the advice of a physician;
16. Pre-existing conditions; however a pre-existing condition will be covered after the plan participant has been continuously insured for 6 months under the same insurance plan;
17. Pregnancy or childbirth, except when conception occurs while covered under the policy; elective abortion; elective cesarean section; or any complications of any of these conditions; pregnancy or childbirth of a dependent when dependent child of an plan participant (except for complications arising there from);
18. Drug, treatment or procedure that either promotes or prevents conception, or prevents childbirth, including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal thereof;
19. Dental care or treatment other than care of sound, natural teeth and gums required on account of injury resulting from an accident while the plan participant is covered under the policy, and rendered within 6 months of the accident;
20. Eyeglasses, contact lenses, hearing aids braces, appliances, or examinations or prescriptions therefore;
21. Weak, strained or flat feet, corns, calluses, or toenails;
22. Expenses incurred during a Hospital room visit which is not of an emergency nature;
23. Treatment paid for or furnished under any other individual or group policy, or other service or medical prepayment plan arranged through the employer to the extent so furnished or paid, or under any mandatory government program or facility set up for the treatment without cost to any individual;
24. Injury sustained while taking part in: mountaineering, hang gliding; parachuting; bungee jumping racing by horse, motor vehicle or motorcycle; snowmobiling; motorcycle/motor scooter riding; scuba diving, involving underwater breathing apparatus, unless PADI or NAUI certified; snorkeling; water skiing; jet skiing; snow skiing; spelunking; parasailing; white water rafting; surfing, unless part of a school credit course; and snow boarding.
25. Practice or play in any amateur, club, intramural, interscholastic, intercollegiate, professional or semiprofessional sports contest or competition;
26. Elective or cosmetic surgery and elective treatment or treatment for congenital anomalies (except as specifically provided), except for reconstructive surgery on a diseased or injured part of the body (correction of a deviated nasal septum is considered cosmetic surgery unless it results from a covered injury or sickness);
27. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from; or while riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.
28. Ionizing radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste, from combustion of nuclear fuel, the radioactive, toxic, explosive or other hazardous properties of any nuclear assembly or nuclear component of such assembly;
29. Plan Participant being exposed to the Utilization of nuclear, chemical or biological weapons of mass destruction



## Definitions

**Eligible Expenses** means the usual, reasonable and customary charges for services or supplies which are incurred by the plan participant for the medically necessary treatment of an injury. Eligible expenses must be incurred while this coverage is in force.

**Plan Participant** means a person and dependent eligible for coverage as identified in the enrollment/application who is a non-United States citizen travelling outside of their home country and has his or her true fixed or permanent home and principal establishment outside of the United States and holds a current and valid passport for whom proper premium payment has been made when due, and who is therefore a plan participant under the policy.

**Dependent** means a plan participant's:

a. lawful spouse, if not legally separated or divorced, or domestic partner or civil union partner.

b. unmarried children under age 26.

The age limitations will not apply to a plan participant's unmarried child who is incapable of self-support due to a mental or physical incapacity. Proof of such incapacity must be furnished to the company immediately upon enrollment or within 31 days of the child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year period following the age limitation.

**Spouse** means lawful spouse, if not legally separated or divorced or domestic partner or civil partner.

**Annual Maximum** means the maximum payable limit per term of coverage up to a maximum of 364 days.

**Lifetime Medical Maximum** means the maximum payable limit for all consecutive terms of coverage.

**Child** means the plan participant's natural child, adopted child (or child placed in the plan participant's home for purposes of adoption), foster child, stepchild, or other child for whom the plan participant has legal guardianship (proof will be required). A child must reside with the plan participant in a parent-child relationship. NOTE: In the event the plan participant shares physical custody of the child with another parent, the requirement that the child reside with the plan participant will be waived.

**Injury** means bodily harm resulting, directly and independently of disease or bodily infirmity, from an accident after the effective date of a plan participant's coverage under the plan document, while this coverage is in force as to the person whose Injury is the basis of the claim. All injuries to the same plan participant sustained in one accident, including all related conditions and recurring symptoms of the injuries will be considered one injury.

**Physician** means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a plan participant, a plan participant's spouse, son, daughter, father, mother, brother or sister or other relative.

**Pre-Existing Condition** means an Injury or sickness, disease, or other condition during the 365 day period immediately prior to the date the plan participant's coverage is effective for which the plan participant: 1) received or received a recommendation for a test, examination, or medical treatment for a condition which first manifested itself, worsened or became acute or had symptoms which would have prompted a reasonable person to seek diagnosis, care or treatment; or 2) took or received a prescription for drugs or medicine. Item (2) of this definition does not apply to a condition which is treated or controlled solely through the taking of prescription drugs or medicine and remains treated or controlled without any adjustment or change in the required prescription throughout the 365 day period before coverage is effective under the plan participant's plan.

## Definitions (continued)

**Sickness** means sickness or disease contracted and causing loss commencing while the coverage is in force as to the plan participant whose sickness is the basis of claim. Any complication or any condition arising out of a sickness for which the plan participant is being treated or has received Treatment will be considered as part of the original sickness.

**Usual, Reasonable and Customary** means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

- The actual amount charged by the provider;
- The negotiated rate; or
- The charge which would have been made by the provider (physician, hospital, etc) for a comparable service or supply made by other providers in the same geographic area, as reasonable determined by us for the same service or supply.

Geographic area means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative crosssection of charge for a like treatment, service, procedure, device drug or supply.

**Preferred Allowance** means the amount a network provider will accept as payment in full for eligible expenses.

**Benefit Period** means the period of time from the date of the accident causing the Injury for which benefits are payable, as shown in the schedule of benefits, and the date after which no Further benefits will be paid.

For a complete list of definitions, see the plan document on file with the plan manager.

## Assistance Services

Assistance services are provided by On Call International. An outline of the assistance services appears below.

### Pre-Travel Assistance

- Help in arranging special medical services needed while travelling

### Medical Emergency Services

- Worldwide, 24-hour medical location service
- Medical case monitoring, arrange communication between patient, family, physicians, employer, consulate, etc.
- Medical transportation arrangements
- Emergency message service for medical situations

### Legal Assistance

- Worldwide, 24-hour contact for non-criminal legal emergencies
- Legal referral to help you locate a consular official or attorney

### Travel Assistance

- Help with lost passports, tickets and documents

### On Call International

- U.S. or Canada: (866) 509-7715
- International: Contact International Operator to place your call to (603) 328-1728
- E-mail for emergencies to mail@oncallinternational.com

Underwritten by: Advent Underwriting Ltd.  
on behalf of Advent Syndicate 780 at Lloyd's

This brochure provides you with a summary of the benefits of ISO J Exchange Visitors insurance plans, as underwritten by Advent Underwriting Ltd. on behalf of Advent Syndicate 780 at Lloyd's. Lloyd's is rated A (Excellent) by AM Best Company 2015.

Please keep this brochure as a summary of the insurance plan as specified in the Policy that is on file with ISO-International Student Organization. The Policy contains a complete description of all of the same terms and conditions outlined in this brochure including: benefits, limitations, and exclusions as underwritten by Advent Underwriting Ltd. on behalf of Advent Syndicate 780 at Lloyd's. In the event of a discrepancy, the policy will prevail.

## Refund of Premium

Premium refunds, less a processing fee, will be considered only for entry into the armed forces. Unearned funds will be refunded for the number of full months only. The refund request must be in writing and your medical insurance ID card must be returned with your request. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to approval by the program manager.

**A \$50 ISO processing fee is applied to all approved cancellation.**

## PPO - Preferred Provider Organization

Students insured under this plan may choose to be treated within or outside of the First Health or Multiplan Networks.

First Health – (800) 226-5116 / [www.myfirsthealth.com](http://www.myfirsthealth.com)

MultiPlan – (888) 342-7427 / [www.multipan.com](http://www.multipan.com)

# Subscription Agreement

I hereby apply to be a plan participant of ISO - International Student Organization established in the Cayman Islands (the "trust") and to participate in the insurance coverage extended by certain underwriters at Lloyd's (the "insurers") to plan participants under the trust (the "coverage"). I understand that the coverage is not a general health insurance product, but is intended for use in the event of a sudden and unexpected event while travelling outside my home country. I understand that the coverage extended to me will terminate upon my return to my home country unless I qualify for a benefit period or home country coverage. I understand that I may obtain full details of the coverage by requesting a copy of the master policy from the plan manager. I understand that the liability of the insurers as underwriters of the coverage is as provided in the master policy. By acceptance of coverage and/or submission of any claim for benefits, the plan participant ratifies the authority of the signer to so act and bind the plan participant.

The plan participant undertakes to make all premium payments as they fall due in respect of the coverage extended to them. The trustee shall not be responsible for the administration of such payments.

If the plan participant fails to make any premium payment due in respect of the coverage extended to them, subject to the discretion of the insurance company, such coverage will lapse.

The plan participant hereby confirms the accuracy of all information validity of all representations and warranties provided to the trustee in connection with its participation in the plan and/or the subscription for the insurance coverage, howsoever provided, including the terms of this subscription agreement, (together "representations & warranties"). The plan participant acknowledges that certain of such information will be relied upon by the insurers as providers of the coverage and that any inaccuracy therein may result in the invalidity of such coverage as it relates to the plan participant, the loss of coverage and all monies paid in relation thereto. The plan participant hereby undertakes to inform the trustee of any change to any of matter that forms the subject of any of the representation & warranties. The plan participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by any inaccuracy in any representation & warranty or failure to advise the trustee of any change in any matter that forms the subject of any of the representation & warranties. The plan participant agrees that the trustee shall be entitled to rely on and to act in accordance with any written instruction purported to be provided by the plan participant and the plan participant hereby undertakes to indemnify and hold harmless the trustee against any loss or damage (including attorney's fees) occasioned by the trustee acting in accordance with any such instruction.

Payments under the terms of the coverage shall be paid by the Insurers to the plan participant or directly to a provider if assignment of benefits has been authorized. The trustee shall not be responsible for the administration of such payments.

I confirm that I have satisfied myself that the Coverage is appropriate for me and that I meet the eligibility criteria.

This insurance is not subject to, and will not be administered as a PPACA (Patient Protection and Affordable Care Act) insurance plan. PPACA requires certain US residents and citizens obtain PPACA compliant insurance coverage. This plan is not designed to cover US residents and citizens. This policy is not subject to guaranteed issuance or renewal.

# Enrollment Form

**For immediate online enrollment visit [www.isoa.org](http://www.isoa.org)**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

S.S.# / school ID: \_\_\_\_\_

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex:  Male  Female  
month day year

Visa:  J1 Other: \_\_\_\_\_

Name of school: \_\_\_\_\_

Home country (passport country): \_\_\_\_\_

Country of permanent residence (if different from home country)  
\_\_\_\_\_  
\_\_\_\_\_

U.S. address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile phone: \_\_\_\_\_

Home phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please start my coverage on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

**You are eligible if you are a participant of ISO – International Student Organization. You must be outside your home country/country of permanent residence to receive the benefits of coverage.**



**(800) 244-1180 \* [mailbox@isoa.org](mailto:mailbox@isoa.org) \* [www.isoa.org](http://www.isoa.org)**

# Enrollment Form (continued)

Rates and benefits are valid for enrollment between April 1, 2016 and March 31, 2017.

I wish to enroll under (please check one):

J1 Exchange (LF003236)

J1 Exchange Superior (LF003237)

- 1** Applicant:  
number of months \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_
- 2** Spouse:  
number of months \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_
- 3** Child 1:  
number of months \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_
- 4** Child 2:  
number of months \_\_\_\_\_ x \$ \_\_\_\_\_ = \$ \_\_\_\_\_
- 5** Annual Service Fee = \$ 16
- 6** Total payment enclosed  
(This sum must equal sum of payment) = \$ \_\_\_\_\_

\*Please note that number of months must match for all applicants.

**Comments:** \_\_\_\_\_

Please charge my credit card:  Visa  MC  AMEX  Discover

Card number: \_\_\_\_\_

Name as appears on credit card: \_\_\_\_\_

Expiration date: \_\_\_\_\_ / \_\_\_\_\_  
month year

Billing address (if different from mailing address)  
\_\_\_\_\_

Signature of card holder: \_\_\_\_\_

Complete name and date of birth if insurance is requested

Spouse: \_\_\_\_\_  
Last First month/day/year Gender Visa Type

Child 1: \_\_\_\_\_  
Last First month/day/year Gender Visa Type

Child 2: \_\_\_\_\_  
Last First month/day/year Gender Visa Type

**I wish to enroll for insurance under the terms of this brochure.**

**I have read the Subscription Agreement contained in this brochure and agree to the Terms and Conditions of such subscription.**

**Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Signature \_\_\_\_\_ month/day/year

**If paying by check, please make a check payable to ISOA and mail to:  
150 West 30th Street, Suite 1101, New York, NY 10001  
For immediate enrollment, visit [www.isoa.org](http://www.isoa.org)  
Fax form to: (212) 262-8920 (if paying by credit card)**