ENROLLMENT FORM

Relation™ EDUCATION SOLUTIONS

2022–2023

IRVINE VALLEY COLLEGE

INTERNATIONAL STUDENT HEALTH INSURANCE PLAN (ISHIP)

Please complete the information on both sides. Print clearly and answer **all** questions thoroughly, then mail to the address on Page 2 prior to the enrollment deadline date. Incomplete forms will not be accepted.

For questions about enrollment, contact Relation Insurance Services at (800) 537-1777.

STUDENT INFORMATION.

STUDENT'S LAST NAME	STUDENT'S FIRST NAME		MI
STUDENT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)			APT / UNIT #
CITY		STATE	ZIP
STUDENT'S DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH ☐ FEMALE ☐ MALE	STUDENT'S PHONE NUMBER	STUDENT'S SCHOOL ID NUMBER
STUDENT'S EMAIL ADDRESS			OK TO CONTACT YOU VIA EMAIL? ☐ YES ☐ NO
ARE YOU AN INTERNATIONAL STUDENT? ☐ YES ☐ NO	IF YES, WHAT IS YOUR HOME COUNTRY OR COUNTRY OF REGULAR DOMICILE?		PASSPORT VISA TYPE: ☐ F1 ☐ J1 ☐ OTHER _____

SELECT THE COVERAGE AND CALCULATE THE TOTAL CHARGES.

	ANNUAL 08/01/2022 to 07/31/2023	**FALL** 08/01/2022 to 12/31/2022	**SPRING / SUMMER** 01/01/2023 to 07/31/2023	**SUMMER** 05/01/2023 to 07/31/2023	**TOTAL AMOUNT DUE**
ENROLLMENT DEADLINE DATE	**09/01/2022**	**09/01/2022**	**02/01/2023**	**06/01/2022**	= **$**
COST OF COVERAGE	☐ $ 2,244.00	☐ $ 935.00	☐ $ 1,309.00	☐ $ 561.00	

Plan costs include the medical insurance premium and administrative fees.

REMIT PAYMENT IN U.S. FUNDS ONLY.

Make check or money order payable to "**Relation Insurance Services**" or complete credit card information.

Credit card authorization charge will appear as "**Student Health Insurance, Relation**" on the credit card statement.

CREDIT CARD #		EXPIRES (MM / YY) /	CSV CODE
NAME OF CARDHOLDER (PLEASE PRINT)			CHARGE AMOUNT: $
CARDHOLDER'S BILLING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)			APT / UNIT #
CITY	STATE / ZIP		COUNTRY

By signing below, I authorize my credit card to be charged the amount listed above for the coverage selected under the Irvine Valley College International Student Health Insurance Plan.

I ACCEPT THE FOLLOWING CANCELLATION / REFUND POLICY.

There are no premium refunds, except when the Plan participant leaves school and permanently returns to his or her home country, or enters the armed forces of any country, and there are no claims on file. A refund request must be sent in writing to **clientservices@relationinsurance.com** with reason for cancellation. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to approval of Relation Insurance Services and / or the insurance company.

CARDHOLDER SIGNATURE _____ **DATE**_____

I CERTIFY THAT I AM ENROLLED AT IRVINE VALLEY COLLEGE. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE INFORMATION CONTAINED IN THE IRVINE VALLEY COLLEGE INTERNATIONAL STUDENT HEALTH INSURANCE PLAN CERTIFICATE AND ELECT TO ENROLL FOR THE COVERAGE SPECIFIED HEREIN.

STUDENT SIGNATURE _____ **DATE**_____

RETURN THIS FORM WITH PAYMENT TO RELATION INSURANCE SERVICES, PO BOX 240042, LOS ANGELES, CALIFORNIA 90024
MUST BE POSTMARKED BY THE APPLICABLE DEADLINE DATE.

NO-COST LANGUAGE ASSISTANCE SERVICES.

You are eligible to access the services of an interpreter to have insurance documents read to you in your native or preferred language, at no cost to you. To use this free service, call the number listed on your insurance ID card or **(877) 657-5030, TTY 711**. For further help, call the CA Department of Insurance at **(800) 927-4357.**

If there are any discrepancies between this document and the Certificate, the Certificate will govern.