

World Class Study Abroad Plan

An application of insurance for U.S. students studying abroad

administered by

Cultural Insurance Services International (CISI)

River Plaza

9 West Broad Street

Stamford, CT 06902-3788

203.399.5121

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other offices: Bonn, Cape Town, London, Paris

2011 Enrollment

The Basic Plan and the Comprehensive Plan are underwritten by The Insurance Company of the State of Pennsylvania

SCHEDULE OF BENEFITS

Basic Plan Coverages	Maximum limits	Comprehensive Plan Coverages	Maximum limits
• Medical Expense (per Accident or Sickness)		• Medical Expense (per Accident or Sickness)	
Deductible	\$100	Deductible	Zero
Limit	\$50,000 at 100%	Limit	\$250,000 at 100%
• Unlimited Lifetime Maximum		• Unlimited Lifetime Maximum	
• Accidental Death and Dismemberment	\$10,000	• Accidental Death and Dismemberment	\$10,000
• Medical Evacuation	\$100,000	• Medical Evacuation	\$100,000
• Repatriation/Return of Mortal Remains	\$50,000	• Repatriation/Return of Mortal Remains	\$50,000
• Team Assist	<i>Included</i>	• Team Assist	<i>Included</i>
		• Baggage Loss	\$1,000
		\$50 deductible; \$100 per article (except for cameras \$250)	
		• Emergency Medical Reunion	\$1,500
		• Tuition Refund	50% up to \$1,000
		• Security Evacuation Rider	\$100,000

Covered Accident and Sickness Medical Expenses

Only such expenses, incurred as the result of a Disablement, which are specifically enumerated in the following list of charges, and which are not excluded in the Exclusions section, shall be considered as Covered Expenses:

- Charges made by a Hospital for room and board, floor nursing and other services.
- Charges made for Intensive Care or Coronary Care charges and nursing services.
- Charges made for diagnosis, treatment and Surgery by a Physician
- Charges made for an operating room.
- Charges made for Outpatient treatment.
- Charges made for the cost and administration of anesthetics.
- Charges for medication, x-ray services, laboratory tests and services, the use of radium and radioactive isotopes, oxygen, blood, transfusions, iron lungs, and medical treatment.
- Charges for inpatient physiotherapy, if recommended by a Physician.
- Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Physician or Surgeon.
- Charges made for artificial limbs, eyes, larynx, and orthotic appliances, but not for replacement of such items.
- Local transportation to or from the nearest Hospital by licensed ground ambulance only.
- Nervous or Mental Disorders are payable a) up to \$500 for outpatient treatment; or b) up to \$2,500 on an inpatient basis. The Company shall not be liable for more than one such inpatient or outpatient occurrence per lifetime under the Policy with respect to any one Insured.
- Chiropractic Care and Therapeutic Services shall be limited to a total of \$50 per visit, excluding x-ray and evaluation charges, with a maximum of 10 visits per injury or illness. The overall maximum coverage per injury or illness is \$500 which includes x-ray and evaluation charges.

Eligibility Requirements

Citizens of the U.S. who are enrolled as full-time students at U.S. institutions or on a recognized study abroad program and who are temporarily engaged in international educational or cultural activities outside their home country are eligible for coverage.

Exclusions

For benefits listed in the Schedule of Benefits, this Insurance does not cover:

- Pre-Existing conditions, defined as any Injury or Illness which meets the following criteria:
 1. a condition that would have caused a person to seek medical advice, diagnosis, care or treatment anytime prior to the Effective Date of coverage under the Policy;
 2. a condition for which medical advice, diagnosis, care or treatment was recommended or received anytime prior to the Effective Date of coverage under the Policy.
- Suicide or any attempt thereof, while sane or self destruction or any attempt thereof, while sane.
- Any consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to, or arising in connection with a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war; or b) mutiny, riot, strike, military or popular uprising insurrection, rebellion, revolution, military or usurped power.
- Routine physicals, immunizations, or other examinations

where there are no objective indications or impairment in normal health, including routine care of a newborn infant, and laboratory diagnostic or x-ray examinations, except in the course of a Disablement established by a prior call or attendance of a Physician.

- The refusal of a Physician or Hospital to make all medical reports and records available to the Company will cause an otherwise valid claim to be denied.
- Cosmetic or plastic Surgery, except as the result of a covered accident; for the purposes of the Policy, treatment of a deviated nasal septum shall be considered a cosmetic condition.
- Elective Surgery or Elective Treatment which can be postponed until the Insured Person returns to his/her Home County, where the objective of the trip is to seek medical advice, treatment or Surgery.
- Treatment in connection with alcoholism and drug addiction, or use of any drug or narcotic agent.
- Injury sustained while under the influence of or Disablement due to wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with treatment prescribed and directed by a Physician for a condition which is covered hereunder.
- Congenital abnormalities and conditions arising out of or resulting there from.
- Expenses as a result or in connection with intentionally selfinflicted Injury or Illness.
- Expenses as a result or in connection with the commission of a felony offense.
- Injury sustained while taking part in mountaineering where ropes or guides are normally used; hang gliding, parachuting, bungee jumping, racing by horse, motor vehicle or motorcycle, parasailing.
- Dental care, except as the result of Injury to natural teeth caused by accident (limited to \$250 per tooth per Injury).
- Routine Dental Treatment.
- 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, or abortion.
- Expenses incurred within the Insured Person's home country or country of residence.
- Injury sustained while the Insured Person is riding as a pilot, student pilot, operator or crew member, in or on, boarding or alighting from, any type of aircraft.

Premium Rates

World Class Study Abroad Basic Plan		World Class Study Abroad Comprehensive Plan	
Age	Monthly premium	Age	Monthly premium
up to 25	\$31	up to 25	\$51
26-30	\$51	26-30	\$72
31-40	\$76	31-40	\$97
41-50	\$100	41-50	\$122
51-60	\$150	51-60	\$173
61+	\$261	61+	\$286

Rates are valid until December 31, 2011. Full months only, please.

Policy terms and conditions are briefly outlined in this document. A complete description is contained in the Plan of Insurance which you will receive after your enrollment.

Leaving soon...?

Enroll on-line at www.culturalinsurance.com.

For office use only 09/10
Participant ID# _____

STUDY ABROAD PLAN ENROLLMENT FORM

Please print. Call 203.399.5121 or e-mail cisiwebadmin@culturalinsurance.com with any questions.
Credit card enrollments can be faxed to 203.399.5596.

PARTICIPANT CONTACT INFORMATION:

Name _____ Female Male

U.S. Mailing Address _____

City _____ State _____ Zip _____

Telephone number _____ Email _____

Date of birth ____/____/____

PROGRAM INFORMATION:

U.S. institution where enrolled as student (if applicable) _____

Institution sponsoring study abroad program (if applicable) _____

Name of international institution you will attend _____

Host country _____

Program start date ____/____/____ Program end date ____/____/____

ENROLLMENT INFORMATION:

I want my insurance to begin ____/____/____ and continue for ____ months (maximum 12 whole months only)

Basic Plan Rate (see premium rates section) \$ ____ X ____ months (whole months only) = \$ ____

Comprehensive Plan Rate (see premium rates section) \$ ____ X ____ Months
(whole months only)

Total premiums = \$ ____

Beneficiary's name _____ Relationship _____

PAYMENT INFORMATION:

Check/money order enclosed Visa MasterCard American Express

Please provide the following additional information for credit card payments:

Card number _____ Expiration date ____/____/____

Cardholder's name (please print) _____

Billing address _____

City/Province _____ State _____ Zip _____

Country _____

I have read and understand the terms and conditions of the policy and authorize payment for the above enrollment.

Signature _____ Date ____/____/____

Please allow two weeks for processing. All insurance materials are sent via standard U.S. Mail. Make checks payable (U.S. funds only) to CISI and mail with completed enrollment form to: CISI, River Plaza, 9 West Broad Street, Stamford, CT 06902-3788.
Please contact CISI if you have any questions about this form or the policy.



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