



Lone Star College System Internship students are not immune to sickness and injury. What if you were hospitalized? Your medical bills could seriously impair or completely stop your academic studies.

Who can enroll?

All students participating in clinical, practicum, internship or co-operative coursework related to technical training, allied health occupations, child care, interpreting and cosmetology are eligible to enroll in this plan on a Voluntary basis.

How do I enroll?

You can enroll online or print and mail an enrollment form from www.ahpcare.com/lscsinternship.



Online Access to

- view and download complete plan description
- enroll in coverage online or download enrollment form
- download temporary ID card
- customer service/claims and benefit questions



PLAN OVERVIEW

This is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits and programs and does not constitute a contract. Covered expenses are subject to plan maximums, limitations, and exclusions as described in the policy.

Lifetime Maximum & Deductible

Up to \$5,000 maximum lifetime benefit paid for each covered Injury or Sickness
\$100 Deductible per Covered Person, per Policy Year

INPATIENT

Hospital Expenses	\$500 aggregate maximum per day
Surgery	75% of Usual & Customary up to \$1,000 maximum

OUTPATIENT

Surgery	75% of Usual & Customary up to \$1,000 maximum
Day Surgery Miscellaneous	\$500 maximum
Outpatient Miscellaneous, including <ul style="list-style-type: none"> • Doctor's Office Visits (<i>\$35 maximum 1st visit; \$25 maximum each subsequent visits</i>) • Physical Therapy • Diagnostic X-Rays & Laboratory • Tests and Procedures • Chemotherapy & Radiation Therapy 	\$250 maximum
Medical Emergency	\$500 maximum
Bloodborne Pathogen Exposure <i>\$1,000 maximum</i>	Paid as any other Covered Sickness

2010-2011 Premium Costs and Coverage Periods

Coverage Period	Annual	Fall	Spring/Summer	Summer
	08/21/2010 to 08/21/2011	08/21/2010 to 01/15/2011	01/15/2011 to 08/21/2011	06/01/2010 to 08/21/2010
Student	\$ 364	\$ 147	\$ 217	\$ 80

Coverage becomes effective on the date the coverage period begins or the date the premium is received by the company, whichever is later.

Internship Students Enrollment Form

Student's Name: _____
First Middle Initial Last

Mailing Address: _____
Street or PO Box City State Zip Code

Permanent Address: _____
Street or PO Box City State Zip Code

Email _____ Cell or Telephone Number _____ - _____ - _____
(A confirmation email will be sent upon enrollment.)

Date of Birth ____/____/____ Male ____ Female SSN _____ - _____ - _____ School ID # _____
M D Y

PLEASE CHECK ALL APPROPRIATE BOXES:

Internship Student	Annual 08/21/10 to 08/21/11	Fall 08/21/10 to 01/15/11	Spring/Summer 01/15/11 to 08/21/11	Summer 06/01/11 to 08/21/11
Student	<input type="checkbox"/> \$ 364.00	<input type="checkbox"/> \$ 147.00	<input type="checkbox"/> \$ 217.00	<input type="checkbox"/> \$80.00

PAYMENT INFORMATION

CHARGE FULL AMOUNT \$ _____ CHECK # _____

VISA
 MASTERCARD
 DISCOVER

CHECK AMOUNT \$ _____

CREDIT CARD # _____ - _____ - _____ Expiration Date _____
Month / Year

I hereby authorize Academic HealthPlans to deduct the total premium due from my credit card.

SIGNATURE OF CARDHOLDER: _____ DATE _____

PRINTED NAME OF CARDHOLDER: _____ DATE _____

PREMIUM PAYMENT INSTRUCTIONS: Make check or money order payable to **ACE American Insurance Company** in U.S. dollars or refer to the charge card authorization to charge your premium to Visa, MasterCard, or Discover. Mail this enrollment form along with premium payment to **Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605**. If you have questions, please call Academic HealthPlans at (888) 308-7320. Your canceled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payment whether or not a renewal notice is received.**

NOTICE TO STUDENT AND CARDHOLDER: Coverage will be effective the date the correct premium is received by the Company, or an authorized representative of the Company or the Effective Date of the coverage period, whichever is later, unless otherwise stated in the Master Policy. By signing below, the student and cardholder acknowledges the following: 1) Rates are not pro-rated other than as listed on this enrollment form; 2) Student meets the eligibility requirements for this coverage as described in the Brochure; 3) If it is later determined that the student is not Eligible, coverage will be deemed to have not been in force and the premium will be returned; and 4) Other than Eligibility or entry into the Armed Forces, the premium is not refundable. It is the student's responsibility for timely renewal payments. This insurance plan is underwritten by ACE American Insurance Company.

My signature below certifies that I have read and understand the Student Health Insurance Plan brochure and agree to accept it as applicable to me regarding the terms and conditions stated therein.

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Student's Signature: _____ Date _____
(Signature of Student or Parent if Student is under age 18)