

# INSURANCE ENROLLMENT FORM

Name of Participant \_\_\_\_\_  
(last) (first)

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Are you a U.S. citizen? \_\_\_\_\_

Native Country \_\_\_\_\_ Type of visa \_\_\_\_\_

Permanent mailing address \_\_\_\_\_  
(street)

\_\_\_\_\_ (city) (state) (zip)

Local mailing address \_\_\_\_\_  
(street)

\_\_\_\_\_ (city) (state) (zip)

In which Study Abroad program will you participate? \_\_\_\_\_

What are the dates of the program? \_\_\_\_\_ to \_\_\_\_\_

If you are departing earlier or returning later than the group, you can apply for 30 days of additional insurance coverage at 80 cents per day.

Will you depart on a different date? \_\_\_\_\_

What day and time? \_\_\_\_\_ From where? \_\_\_\_\_

Will you return on a different date? \_\_\_\_\_

What day and time? \_\_\_\_\_ From where? \_\_\_\_\_

Do you want additional coverage? \_\_\_\_\_

For what period (not to exceed 30 days) \_\_\_\_\_

I have enclosed a money order for \$ \_\_\_\_\_ to cover \_\_\_\_\_ days of additional insurance coverage.

*Please make money order payable to HTH Worldwide, Inc.*

Participant's Beneficiary \_\_\_\_\_  
(name and relationship)

Date \_\_\_\_\_ Signature \_\_\_\_\_