ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE

Please fill out the attached enrollment information, select the desired coverage, and return along with the correct premium (check or credit card payment information) to the address listed below.

NOTE - You can purchase this insurance anytime between the Master Policy effective and expiration dates during the current school year.

REMEMBER TO DETACH AND PLACE THE COMPLETED ENROLLMENT FORM WITH THE PREMIUM OR CREDIT CARD PAYMENT INFORMATION TO:
Student Assurance Services, Inc.
P.O. Box 196, Stillwater, MN 55082-0196

In order to make coverage effective, please return this completed enrollment form as soon as possible.

DATE RECEIVED_____

Ameritas
Ameritas Life Insurance Corp.
Lincoln, Nebraska

ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE

↑ STUDENT'S LAST NAME ↑ (one letter in each box)

STUDENT'S FIRST NAME M.I.

Please Print

Address _____
(Street)

_____
(City) (State) (Zip)

Email Address _____

Name of School _____

Name of District _____

Student's Age_____ Grade_____Phone _____

X _____

GAA-2203Ed.11-16 (Signature of Parent or Guardian) (Date)

COVERAGE PLANS	One Time Policy Year Premiums
Full Time Coverage (Does NOT include Inter-scholastic Sports Coverage)	☐ $ 99
Full Time Coverage AND Interscholastic Sports Coverage (Does not include Football Grades 9-12)	☐ $174
School Time Coverage (Does NOT Include Interscholastic Sports Coverage)	☐ $ 16
School Time Coverage AND Interscholastic Sports Coverage (does not include Football Grades 9-12)	☐ $ 91
Football Coverage (Grades 9-12)	☐ $250
Extended Dental Coverage (Grades PK-12)	☐ $ 9

DO NOT SEND CASH **TOTAL PREMIUM**

Make Checks payable to: **STUDENT ASSURANCE SERVICES, INC.**
*Please write student's name on the front of check. **NO REFUNDS**

C-1540(2017)

STUDENT ACCIDENT INSURANCE CREDIT CARD PAYMENT

INDICATE PREMIUM SELECTED AND COMPLETE THE REQUESTED ENROLLMENT INFORMATION FOUND ON THE REVERSE SIDE OF THIS FORM.
There is a $5.00 Processing Fee added to ALL Credit Card Transactions (does not apply to IN residents)

☐ Please charge $ _____ + $5.00 Processing Fee = $ _____ to the following credit card: ☐VISA® ,☐MasterCard®, or ☐Discover®

Credit Card Number | Security Code (on back of card, 3 digits) | Card Expiration Date (Month) (Year)

Credit card billing will state: "Student Assurance Services, Inc."

Print Cardholder Name _____ Date ____ / ____ / ____

Cardholder Signature _____

Cardholder Address _____
(Street) (City) (State) (Zip)

Telephone Number (_____) _____ - _____

GAA-2203Ed.11-16

DETACH - Place inside envelope

C-1540(2017)