

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) as soon as possible.

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

REMEMBER TO FILL-OUT ALL REQUESTED INFORMATION AND RETURN ALONG WITH YOUR 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 _____



ENROLLMENT ENVELOPE FOR STUDENT ACCIDENT INSURANCE

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

M.I.
 STUDENT'S FIRST NAME

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
		BASIC PLAN	PREMIER PLAN
	Full Time Coverage PK-12 AND All Sports (except Football Coverage)	<input type="checkbox"/> \$85	<input type="checkbox"/> \$152
	School Time Coverage PK-8 AND All Sports (except Football Coverage)	<input type="checkbox"/> \$15	<input type="checkbox"/> \$28
	School Time Coverage 9-12 AND All Sports (except Football Coverage)	<input type="checkbox"/> \$48	<input type="checkbox"/> \$90
	Football Coverage Grades 10-12 and grades 7-9 practicing or participating in 10-12 Football	<input type="checkbox"/> \$97	<input type="checkbox"/> \$240
	Extended Dental Coverage Grades PK-12	<input type="checkbox"/> \$8	<input type="checkbox"/> \$8

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-1538

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 NC 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	Credit card billing will state:
<input type="text"/>	<input type="text"/>	(Month) (Year)	"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-1538