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 FILL-OUT ALL REQUESTED INFORMATION AND RETURN ALONG 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 Interscholastic 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**

–

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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