

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 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)

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)	<input type="checkbox"/> \$ 89
	Full Time Coverage AND Interscholastic Sports Coverage (Does not include Football Grades 9-12)	<input type="checkbox"/> \$ 154
	School Time Coverage (Does NOT Include Interscholastic Sports Coverage)	<input type="checkbox"/> \$ 14
	School Time Coverage AND Interscholastic Sports Coverage (does not include Football Grades 9-12)	<input type="checkbox"/> \$ 79
	Football Coverage (Grades 9-12)	<input type="checkbox"/> \$ 185
	Extended Dental Coverage (Grades PK-12)	<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-1513 (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

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."
<div style="border: 1px solid black; display: inline-block; width: 100px; height: 1.2em;"></div>	<div style="border: 1px solid black; display: inline-block; width: 40px; height: 1.2em;"></div>	<div style="border: 1px solid black; display: inline-block; width: 30px; height: 1.2em;"></div> - <div style="border: 1px solid black; display: inline-block; width: 30px; height: 1.2em;"></div>	

Print Cardholder Name _____ Date ____ / ____ / ____

Cardholder Signature _____

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

Telephone Number (_____) _____ - _____

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DETACH - Place inside envelope

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