

PINNACLE ABROAD ADVANTAGE

\$50,000 Medical Benefit

PLEASE PRINT - COMPLETE ALL INFORMATION

Grid for LAST NAME

LAST NAME

Grid for FIRST NAME and MI

FIRST NAME

MI

Grid for MAILING ADDRESS

MAILING ADDRESS

Grid for APARTMENT/UNIT No.

APARTMENT/UNIT No.

Grid for GENDER

MALE FEMALE

Grid for DATE OF BIRTH

DATE OF BIRTH

Grid for CITY

CITY

Grid for STATE

STATE

Grid for ZIP

ZIP

()

TELEPHONE NUMBER

NAME OF COLLEGE/UNIVERSITY YOU ARE ATTENDING:

E-MAIL ADDRESS

COVERAGE: I want coverage to begin on / / and continue for days.

DAILY RATES

Table with columns: Student/Scholar, Plan A No Deductible, Plan B \$100 Deductible per Condition, NO. OF DAYS (10 Days Minimum Required), TOTAL PREMIUM To be Submitted. Rows for Age groups 28-64.

By your signature hereon, acknowledgement is made that 1) you and any insured meet the eligibility requirements as described within the insurance brochure; and 2) if at any time it is determined you did not meet the eligibility requirements for this coverage, the only liability the Company has is the refund of premium, subject to any claims for which benefits had been paid prior to discovery of the ineligibility.

Signature - Student - Parent - Guardian

Date

METHOD OF PAYMENT:

- Check / Money Order* Payable To: AMA & Associates
Credit Card - The Company will charge 4% of your total premium for processing via your credit card.

CREDIT CARD PAYMENT AUTHORIZATION - Please bill my credit card for my insurance. (Complete credit card information below.)

AMOUNT CHARGED \$ MASTER CARD VISA

Grid for LAST NAME

LAST NAME

Grid for FIRST NAME

FIRST NAME

Grid for MI

MI

Grid for CREDIT CARD NUMBER

CREDIT CARD NUMBER

Grid for EXP. DATE

EXP. DATE

SIGNATURE - CARDHOLDER

DATE

MAIL TO: AMA & Associates, P. O. Box 659570, San Antonio, TX 78265