

ENROLLMENT FORM INTERNATIONAL STUDENT/SCHOLAR ACCIDENT & SICKNESS INSURANCE
PINNACLE ELITE GOLD PLAN

2661

PLEASE PRINT - COMPLETE ALL INFORMATION

LAST NAME												FIRST NAME				MI		
U. S. MAILING ADDRESS												APARTMENT/UNIT NO.		MALE	FEMALE	Mo.	DAY	YEAR
CITY						STATE	ZIP		TELEPHONE NUMBER									
NAME OF COLLEGE/UNIVERSITY YOU ARE ATTENDING:												E-MAIL ADDRESS						

COVERAGE: I want coverage to begin on ____/____/____ and continue for ____ whole months.
 Any fraction of a month must be calculated as a whole month.

<u>MONTHLY RATES</u>	<u>NO. OF MONTHS</u> (3 Months Minimum Required)	<u>TOTAL PREMIUM</u>
Student \$111.00	X _____	= \$ _____
Spouse * \$278.00	X _____	= \$ _____
Each Child * \$139.00	X _____	= \$ _____
Children (3 or more)* \$417.00	X _____	= \$ _____

*Dependent coverage is only available if the Student/Scholar enrolls in this program, and coverage cannot begin before or extend beyond that of the Student/Scholar.

Indicate Total Premium Submitted: \$ _____

By your signature hereon, acknowledgement is made that 1) you and any insured family member meet the eligibility requirements as described within the insurance brochure; and 2) if at any time it is determined you, or any insured family member, 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

LAST NAME												FIRST NAME				MI
CREDIT CARD NUMBER												Mo.	YEAR	EXP. DATE		
SIGNATURE - CARDHOLDER												DATE				

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

DEPENDENTS TO BE INSURED

SPOUSE - LAST NAME												<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	FIRST NAME				MI	Mo.	DAY	YEAR	DATE OF BIRTH
CHILD - LAST NAME												<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	FIRST NAME				MI	Mo.	DAY	YEAR	DATE OF BIRTH
CHILD - LAST NAME												<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	FIRST NAME				MI	Mo.	DAY	YEAR	DATE OF BIRTH
CHILD - LAST NAME												<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	FIRST NAME				MI	Mo.	DAY	YEAR	DATE OF BIRTH