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 | DATE OF BIRTH (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.

	MONTHLY RATES		NO. OF MONTHS (3 Months Minimum Required)	TOTAL PREMIUM
Student	$111.00		x _____ =	$_____
Spouse *	$278.00		x _____ =	$_____
Each Child *	$139.00	x _____ (No. Children)	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 ineligibilty.

_____ ____/____/____
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 | EXP. DATE (MO. YEAR)

_____ ____/____/____
SIGNATURE - CARDHOLDER | DATE

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

DEPENDENTS TO BE INSURED

SPOUSE - LAST NAME ☐ MALE ☐ FEMALE FIRST NAME MI DATE OF BIRTH (MO. DAY YEAR)

CHILD - LAST NAME ☐ MALE ☐ FEMALE FIRST NAME MI DATE OF BIRTH (MO. DAY YEAR)

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