2018-2019
ENROLLMENT FORM

DEPENDENT Enrollment Form
For International Student/Scholar Injury & Sickness Insurance
PURDUE UNIVERSITY - FORT WAYNE

2625

PLEASE **PRINT** - COMPLETE ALL INFORMATION

LAST NAME   FIRST NAME   MI

U. S. MAILING ADDRESS   APARTMENT/UNIT NO.   MALE FEMALE   Mo. DAY YEAR / DATE OF BIRTH

CITY   STATE   ZIP CODE   (   ) TELEPHONE NUMBER

E-MAIL ADDRESS

Coverage will become effective the latest of: the Policy effective date, requested date of coverage, or the day after the date of postmark.

COVERAGE: I want coverage to begin on ____/____/____ and continue for _____ whole months.

Any fraction of a month must be calculated as a whole month.   Pro-rating of the monthly rate is not acceptable.

Policy Effective Date: 8-01-18

	MONTHLY RATES	NO. OF MONTHS (3 Months Minimum Required)	TOTAL PREMIUM
Spouse *	$368.00	X _____	= $_____
Each Child *	$184.00	X _____	= $_____
Children (3 or more)*	$552.00 x _____ (No. Children)	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 insured
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

MAIL TO:
**AMA & Associates
P. O. Box 65139
San Antonio, TX 78265**

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

AMOUNT CHARGED $ _____   ☐ MASTER CARD   ☐ VISA

CARDHOLDER - LAST NAME   CARDHOLDER - FIRST NAME   MI

CREDIT CARD NUMBER   Mo. YEAR / EXP. DATE   3 DIGIT SECURITY CODE
                                                      (ON BACK OF CARD).
CARDHOLDER SIGNATURE   ____/____/____ DATE   THIS MUST BE PROVIDED
                                                      TO PURCHASE COVERAGE.

DEPENDENTS TO BE INSURED

SPOUSE - LAST NAME ☐ MALE ☐ FEMALE	FIRST NAME	MI	Mo. DAY YEAR / DATE OF BIRTH
CHILD - LAST NAME ☐ MALE ☐ FEMALE	FIRST NAME	MI	Mo. DAY YEAR / DATE OF BIRTH
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