2012-2013

DEPENDENT - Enrollment Form
For International Student Accident & Illness Insurance
UNIVERSITY OF ILLINOIS @ CHICAGO - TUTORIUM IN INTENSIVE ENGLISH

2478

PLEASE PRINT - FAILURE TO PROVIDE ALL INFORMATION MAY DELAY OR VOID YOUR INSURANCE

LAST NAME | FIRST NAME | MI

MAILING ADDRESS | APARTMENT/UNIT NO. | DATE OF BIRTH (MO. DAY YEAR) | MALE | FEMALE

CITY | STATE | ZIP | SOC. SEC. NO.

TELEPHONE NUMBER | FAX NUMBER | E-MAIL ADDRESS

Dependent coverage is only available to students enrolled in this student insurance program, and cannot begin before or extend beyond the insured student's coverage.

PREMIUM RATES

Please indicate coverage desired:

	SPOUSE	EA CHILD
Summer: 5-14-12 through 8-21-12	☐ $ 903	☐ $ 455
Mid-Summer - 6-18-12 through 8-21-12	☐ $ 593	☐ $ 298
Fall: 8-22-12 through 1-6-13	☐ $ 1,261	☐ $ 635
Mid-Fall: 10-8-12 through 1-6-13	☐ $ 830	☐ $ 417
Spring: 1-7-13 through 5-14-13	☐ $ 1,172	☐ $ 590
Mid-Spring: 2-25-13 through 5-14-13	☐ $ 730	☐ $ 367

Indicate Total Premium submitted: _____

STUDENT NOTICE - By placement of your signature hereon, acknowledgment is made that: 1) you have carefully read the insurance coverage brochure; 2) you and any insured family member meet the eligibility requirements as described within the insurance brochure; 3) 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; 4) the Company assumes no responsibility for notification to the insured prior to or at the termination of coverage for any insured period.

_____ _____/_____/_____

SIGNATURE - STUDENT - PARENT - GUARDIAN | **DATE**

METHOD OF PAYMENT

☐ CHECK /MONEY ORDER **PAYABLE TO**: **AMA & ASSOCIATES**

☐ **CREDIT CARD PAYMENT AUTHORIZATION** - Please bill my credit card for my insurance. ☐ **MASTER CARD** ☐ **VISA**

AMOUNT CHARGED $ _____ **THE COMPANY WILL CHARGE 4% OF YOUR TOTAL PREMIUM FOR PROCESSING VIA YOUR CREDIT CARD.**

LAST NAME | FIRST NAME | MI

CREDIT CARD NUMBER | EXP. DATE (MO. YEAR)

_____ _____/_____/_____

SIGNATURE - STUDENT - PARENT - GUARDIAN | DATE

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

DEPENDENTS TO BE INSURED

SPOUSE - LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MO. DAY YEAR)
CHILD - LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MO. DAY YEAR)
CHILD - LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MO. DAY YEAR)
CHILD - LAST NAME	FIRST NAME	MI	DATE OF BIRTH (MO. DAY YEAR)