2018-2019
ENROLLMENT FORM

OPTIONAL PRACTICAL TRAINING STUDENT
International Accident & Sickness Insurance
SAGINAW VALLEY STATE UNIVERSITY

2586

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 CODE | ( ) TELEPHONE NUMBER

E-MAIL ADDRESS

An OPT student must be involved in training directly related to his/her major area of study at Saginaw Valley State University. This coverage is not available to those residing in the states of: California, Colorado, Maryland, Massachusetts, New Hampshire, New York, and Washington.

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

Policy Effective Date: 8-19-17

MONTHLY RATES				NO. OF MONTHS (3 Months Minimum Required)		TOTAL PREMIUM
OPT Student	$182.00		x	________	=	$________
Spouse *	$456.00		x	________	=	$________
Each Child *	$228.00	x ________ (No. Children)	x	________	=	$________
Children (3 or more)*	$684.00		x	________	=	$________

Indicate Total Premium Submitted: $ ________

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

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/Scholar - 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 | EXP. DATE (MO. YEAR) | 3 DIGIT SECURITY CODE (ON BACK OF CARD). THIS MUST BE PROVIDED TO PURCHASE COVERAGE.

CARDHOLDER SIGNATURE | DATE ___/___/___

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