

**\$100,000 DEDUCTIBLE**

Student Social Security Number \_\_\_\_\_ Student Date of Birth \_\_\_\_\_

Name of Student \_\_\_\_\_  Male  Female  
Last Name First Name MI

Address \_\_\_\_\_  
Street City State Zip Code

Name of College/University Attending \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

**I would like to participate in this program. Please enroll me (and my dependents) during the following term: (please mark the appropriate box)**

	Annual		Spring through Summer	
	Under 25	Over 25	Under 25	Over 25
<input type="checkbox"/> Student	<input type="checkbox"/> \$ 100	<input type="checkbox"/> \$ 125	<input type="checkbox"/> \$ 75	<input type="checkbox"/> \$ 95
<input type="checkbox"/> Spouse	<input type="checkbox"/> \$ 225	<input type="checkbox"/> \$ 265	<input type="checkbox"/> \$ 169	<input type="checkbox"/> \$ 200
<input type="checkbox"/> Each Child	<input type="checkbox"/> \$ 90	<input type="checkbox"/> \$ 90	<input type="checkbox"/> \$ 68	<input type="checkbox"/> \$ 68

(Please list the Names of the dependents below)

Coverage becomes effective on the date of the applicable term for which premium is paid or the day following the date the enrollment form and correct premium for such period of coverage are received. Coverage terminates at 12:01 a.m. on the termination date of the applicable policy term for which premium is paid. Please check method of payment below.

**DEPENDENTS LISTING**

I wish to extend my own coverage to include my following dependents (spouse and unmarried children under 19):

Dependents Name	Social Security No.	Date of Birth	Relationship to Student	Male / Female
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

This is only a brief description of the coverage. The policy may contain reductions, limitations, exclusions, and termination provisions. Full details of the coverage are contained in the policy. If there is any conflict between the contents of this document and the policy, or if any point is not covered in this document, the terms and conditions of the policy will govern all cases.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

I acknowledge that I have read, understand, and agree to the terms and conditions of this coverage as detailed in the brochure.

**Please submit enrollment form and premium payment to : American Management Advisors, Inc. PO Box 366 Langhorne, PA 19047**