TERM PERIOD ❒ 08-15-06 to 12-14-06 ❒ 12-15-06 to 04-14-07 ❒ 04-15-07 to 08-14-07

	TRI-ANNUAL PREMIUMS*	
	PLAN I	**PLAN II**
Student Only - Under Age 30	❒ $ 90.00	❒ $ 235.00
Each Dependent	❒ $ 225.00	❒ $ 590.00
Student Only - Age 30 and Over	❒ $ 135.00	❒ $ 330.00
Each Dependent	❒ $ 340.00	❒ $ 825.00

Please indicate the Plan and Term Period for which You are enrolling. Premiums are not prorated. The total premium must be paid for the term you enroll in even though the term may be in progress. Your coverage becomes effective on the later of: the Policy effective date (08-15-2006); the first day of the term for which the proper premium has been paid; or 12:01 A.M. following the date the proper premium is received by the Plan Administrator. All coverage expires on the earlier of: 08-14-2007; or when the premium is due and unpaid. It is your responsibility to make timely premium payments regardless of whether or not you receive a premium notice. *If purchasing partial year coverage, the same plan must be selected for subsequent coverage periods.

MAKE CHECKS PAYABLE TO: STUDENT ASSURANCE SERVICES, INC. • P.O. Box 196 • Stillwater, MN 55082-0196

NO REFUNDS, except as provided in the Master Policy.

A276CFG(IA,NE,SD,WI) R-10-32-47-133-173-174 (enr)

STUDENT ASSURANCE SERVICES, INC.
P O BOX 196
STILLWATER MN 55082-0196

PLACE STAMP HERE
POST OFFICE WILL NOT DELIVER WITHOUT POSTAGE

Return Address

R-10-32-47-133-173-174(enr)

2006-2007 STUDENT ACCIDENT & SICKNESS INSURANCE ENROLLMENT FORM

☒ **COLUMBIAN LIFE INSURANCE COMPANY** • Home Office: Chicago, IL • Administrative Service Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381
❐ **COLUMBIAN MUTUAL LIFE INSURANCE COMPANY** • Home Office: Vestal Parkway E., P.O. Box 1381 • Binghamton, NY 13902-1381

School's Name ______________________________ Date ______________

Student's Name ______________________________
(Please Print)

Soc. Sec. # ☐☐☐ - ☐☐ - ☐☐☐☐ Birthdate ______________ ❐ UnderGraduate ❐ Graduate ❐ International
(MM/DD/YY)

Billing Address ______________________________ ______________
(Street) (e-mail Address)

______________________________ ______________
(City) (State) (Zip) (Phone Number)

Dependent Information (complete if purchasing dependent coverage).

Spouse's Name ______________ Soc Sec# ______________ Birthdate ______________
(MM/DD/YY)

Child's Name ______________ Soc Sec# ______________ Birthdate ______________
(MM/DD/YY)

Child's Name ______________ Soc Sec# ______________ Birthdate ______________
(MM/DD/YY)

I understand the policy excludes all benefits for a condition which originates, is diagnosed, treated or recommended for treatment within 12 months immediately prior to my Effective Date of coverage under the policy.

Student Signature ______________________________ Date____/____/____

A276CFG(IA,NE,SD,WI) R-10-32-47-133-173-174(enr)