	<b>2023-2024 ENROLLMENT FORM FOR STUDENTS of</b> <b>Southern Union State Community College</b> <b>Student Fixed Indemnity</b> Policy Number: WI2324ALIND04 Group Number: ST1775FI <b>Participant Accident</b> Policy #: WI2324ALACC08 Group Number: ST1775AC Underwritten by Wellfleet Insurance
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<b>STUDENT:</b> Complete information below for student. <i>PLEASE PRINT LEGIBLY.</i>			
<b>FIRST NAME:</b>		<b>LAST NAME:</b>	
<b>STUDENT ID #:</b>	<b>GENDER:</b> Male Female	<b>Date of Birth:</b>	
<b>MAILING ADDRESS</b> – House/Building Number and Street Name:			
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>	
<b>CELL PHONE #:</b>		<b>EMAIL ADDRESS:</b>	


INSURANCE COSTS COMBINED - PLAN A (Fixed Indemnity) & PLAN B (Accident)					
Check period of coverage:					
	Annual 8/15/2023–8/14/2024	Fall 8/15/2023 – 1/14/2024	Spring 1/15/2024 - 5/15/2024	Spring/Summer 1/15/2024 – 8/14/2024	Summer 5/15/2024 – 8/14/2024
<b>Student</b>	\$524.00	\$249.00	\$249.00	\$376.00	\$158.00

**Payment Instructions:** Please mail the completed form and correct premium to: **Parker Waller Insurance – P.O. Box 249, Greenville, AL 36037**. Payment should be made in the form of a Personal Check, US Bank Check or US Money Order and made payable to **Parker Waller Insurance, LLC**.

**NOTICE TO STUDENT:** Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless otherwise stated in the Policy Certificate. By signing, the student acknowledges the following: 1) He/She has carefully read the plan and elects to enroll as indicated on this enrollment card; 2) He/She meets the eligibility requirements for this coverage as described in the plan; and 3) If it is later determined that the student is not eligible, the premium will be refunded.

**STUDENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Questions? Please contact Parker Waller Insurance at 334-382-1234**


Name: _____ Student ID#: _____ Southern Union State Community College Fixed Indemnity – ST1779FI Participant Accident – ST1779AC Fully Insured by Wellfleet Insurance Company

This card is for identification purposes only and does not guarantee eligibility. <b>To verify coverage and eligibility, call Wellfleet at 1-877-657-5030</b>	
<b>Forward all claims to:</b> Wellfleet Insurance PO Box 15369 Springfield, MA 01115 Payer ID: 87843	<div style="border: 1px solid black; padding: 5px;"> <b>PHARMACY</b>          Member must pay for prescription and submit itemized receipt to Wellfleet for reimbursement.       </div>