WELLFLEET
STUDENT

2025-2026 ENROLLMENT FORM FOR STUDENTS of

Southern Union State Community College

Student Fixed Indemnity
Policy Number: WI2526ALIND04
Group Number: ST1775FI

Participant Accident
Policy #: WI2526ALACC08
Group Number: ST1775AC
Underwritten by: Wellfleet Insurance

STUDENT: Complete information below for student. ***PLEASE PRINT LEGIBLY.***			
FIRST NAME:		**LAST NAME:**	
STUDENT ID #:	**GENDER:** ☐ Male ☐ Female	**Date of Birth:**	
MAILING ADDRESS – House/Building Number and Street Name:			
CITY:	**STATE:**	**ZIP CODE:**	
CELL PHONE #:	**EMAIL ADDRESS:**		

INSURANCE COSTS COMBINED - PLAN A (Fixed Indemnity) & PLAN B (Accident) **Check period of coverage:**					
	Annual **8/15/2025–8/14/2026**	**Fall** **8/15/2025 – 1/14/2026**	**Spring** **1/15/2026 - 5/15/2026**	**Spring/Summer** **1/15/2026 – 8/14/2026**	**Summer** **5/15/2026 – 8/14/2026**
Student	☐ $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

WELLFLEET
STUDENT

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.
To verify coverage and eligibility, call Wellfleet at 1-877-657-5030

Forward all claims to:
Wellfleet Insurance
PO Box 15369
Springfield, MA 01115
Payer ID: 87843

PHARMACY
Member must pay for prescription and submit itemized receipt to Wellfleet for reimbursement.