

2023-2024

Washington State Colleges

ENROLLMENT FORM

Voluntary Student Accident Only Insurance Plan

Please complete the information on both sides. Print clearly and answer all questions thoroughly, as incomplete forms will not be accepted. For questions about enrollment, contact Risk Strategies 913-754-5617.

Student Information

STUDENT'S SCHOOL						
STUDENT'S LAST NAME			STUDENT'S FIRST NAME		MI	
STUDENT'S U.S. MAILING ADDRESS – NUMBER AND STREET NAME (OR P.O. BOX #)					APT/UNIT #	
CITY				STATE	ZIP	
STUDENT'S DATE OF BIRTH (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH FEMALE MALE		STUDENT'S PHONE NUMBER		STUDENT'S SCHOOL ID NUMBER	
STUDENT'S EMAIL ADDRESS				OK TO CONTACT YOU VIA EMAIL?	YES NO	STUDENT'S SOCIAL SECURITY NUMBER

Select the Coverage and Calculate the Total Charges

	ANNUAL 09/01/2023-09/01/2024	FALL QUARTER*	WINTER QUARTER*	SPRING QUARTER*	SUMMER QUARTER*	TOTAL AMOUNT DUE
COST OF COVERAGE	\$147.00	\$39.00	\$39.00	\$39.00	\$39.00	= \$

* Coverage dates are based on the actual dates of your campus. The cost of coverage includes insurance premium and administrative fees.

I accept the following cancellation/refund policy.

There are no premium refunds, except when the Plan participant leaves school or enters the armed forces, and there are no claims on file. A refund request must be sent in writing to kristin.legendre@ahpcare.com with reason for cancellation. Premium refunds will not be considered if a claim has been filed during the period of coverage. All refunds are subject to approval of Risk Strategies and / or the insurance company.

I certify that I am enrolled at a Washington State College.

By signing below, I acknowledge that I have read and understand the information contained in the Washington State Colleges Voluntary Student Accident Only Plan Brochure and elect to enroll for the coverage specified herein.

STUDENT SIGNATURE _____

DATE _____

Credit Card or ACH Payment

Go to: res.epaypolicy.com

- Enter the student's name and email as the payer
- Enter **Washington State Colleges Enrollment -Student Name** as the account name.
- Enter your payment information
- **Once payment is complete, send your completed enrollment form** kristin.legendre@ahpcare.com or fax to (913)754-5617

You will not be enrolled until the enrollment form AND payment are received. If received after the quarter you are enrolling in begins, your effective date will be the date of receipt.

Check Payment

Send enrollment form and check to made Payable to Risk Strategies to:

Risk Strategies
Attn: Kristin Legendre
16201 West 95th Street, Ste. 210
Lenexa, KS 66219

If there are any discrepancies between this document and the Policy, the Policy will govern.