2021–2022 **ENROLLMENT FORM**

WASHINGTON STATE COLLEGES
STUDENT ACCIDENT ONLY INSURANCE PLAN

Complete the information below. Please print clearly and answer **all** questions, then mail to the address listed below. Incomplete forms will not be accepted. **For questions about enrollment, please contact Relation Insurance Services at (800) 955-1991.**

1. ENTER STUDENT INFORMATION:

STUDENT'S LAST NAME	STUDENT'S FIRST NAME		MI
STUDENT'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR PO BOX #)			APT/UNIT #
CITY		STATE	ZIP
STUDENT'S DATE OF BIRTH (MM/DD/YYYY) ☐ 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	
ARE YOU AN INTERNATIONAL STUDENT? ☐ YES ☐ NO	IF YES, WHAT IS YOUR HOME COUNTRY OR COUNTRY OF REGULAR DOMICILE?	PASSPORT VISA TYPE: ☐ F1 ☐ J1 ☐ OTHER _____	

2. SELECT THE COVERAGE YOU WISH TO PURCHASE AND CALCULATE THE TOTAL CHARGES:

	ANNUAL 09/01/2021 to 09/11/2022	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.

3. REMIT PAYMENT IN U.S. FUNDS ONLY. MAKE CHECK OR MONEY ORDER PAYABLE TO: RELATION INSURANCE SERVICES OR COMPLETE CREDIT CARD INFORMATION BELOW.

CREDIT CARD AUTHORIZATION: CHARGE WILL APPEAR AS "STUDENT HEALTH INSURANCE, RELATION" ON YOUR CREDIT CARD BILL.			
CREDIT CARD #			EXPIRATION DATE _____/_____
NAME OF CARDHOLDER (PLEASE PRINT)	CHARGE AMOUNT: $	CSV/CID CODE*:	
By signing below, I authorize my credit card to be charged the amount listed above for the coverage I have selected under the Washington State Colleges Student Accident Only Insurance Plan.			
SIGNATURE OF CARDHOLDER			

4. STUDENT SIGNATURE:
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 Student Accident Only Plan Brochure elect to enroll for the coverage specified above.

SIGNATURE_____ **DATE**_____

5. RETURN THIS FORM WITH PAYMENT TO: RELATION INSURANCE SERVICES, PO BOX 25936, OVERLAND PARK, KANSAS 66225

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