

**Enrollment for Student Accident and Sickness Plan - Please Print**

**Guarantee Trust Life Insurance Company**

Student's Name \_\_\_\_\_ Student # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Are you an Allied Health Student?  Yes  No School Name Oakton Community College

Check (✓) the plan you have selected. For FAMILY COVERAGE, complete application on reverse side.

	8/15/11 to 8/15/12				1/1 /12 to 8/15/12				6/1/12 to 8/15/12 Summer Session	
	Plan I	Plan II	Plan I PLUS \$500,000 Max	Plan II PLUS \$500,000 Max	Plan I	Plan II	Plan I PLUS \$500,000 Max	Plan II PLUS \$500,000 Max	Plan I	Plan II
Student Only	<input type="checkbox"/> \$444	<input type="checkbox"/> \$669	<input type="checkbox"/> \$794*	<input type="checkbox"/> \$1,019*	<input type="checkbox"/> \$257	<input type="checkbox"/> \$386	<input type="checkbox"/> \$520*	<input type="checkbox"/> \$649*	<input type="checkbox"/> \$95	<input type="checkbox"/> \$115
Spouse	<input type="checkbox"/> \$1,706	<input type="checkbox"/> \$2,560	<input type="checkbox"/> \$2,642*	<input type="checkbox"/> \$3,496*	<input type="checkbox"/> \$990	<input type="checkbox"/> \$1,484	<input type="checkbox"/> \$1,692*	<input type="checkbox"/> \$2,186*		
Child	<input type="checkbox"/> \$368	<input type="checkbox"/> \$550	<input type="checkbox"/> \$836*	<input type="checkbox"/> \$1,018*	<input type="checkbox"/> \$213	<input type="checkbox"/> \$318	<input type="checkbox"/> \$535*	<input type="checkbox"/> \$640*		

\*The optional coverage is provided by:  
 MARKEL INSURANCE COMPANY. Please call for rate if you are age 25 or older for \$500,000 Max. Plan only!

Signature: \_\_\_\_\_

I understand that insurance becomes effective only when this application and full premium have been received by **First Agency, Inc.**

**SUPPLEMENTARY ENROLLMENT FOR FAMILY COVERAGE**

**I wish to extend my own coverage to include my following dependents (spouse and unmarried children under age 19)**

**Dependent's Name**

**Date of Birth**

**Relationship to Insured**

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

---

Signature

---

Date Signed