

INCREASED SUPPLEMENTAL LIMIT & CATASTROPHIC MAJOR MEDICAL ENROLLMENT FORM FOR CHOWAN UNIVERSITY

Student Name: _____ Telephone No.:(_____) _____

Student Address: _____ City: _____ State: _____ Zip: _____

Student Date of Birth: ____/____/____ Student I.D. Number: _____

Premium Enclosed: Annual Enrollment
 \$308 Increased Supplemental Limit
 \$280 Catastrophic Major Medical Under Age 25*
 \$490 Catastrophic Major Medical Over Age 25*

Spring Enrollment
 \$210 Increased Supplemental Limit
 \$210 Catastrophic Major Medical Under Age 25*
 \$368 Catastrophic Major Medical Over Age 25*

*This Plan is underwritten by Markel Insurance Company

Amount enclosed: \$ _____ Check or money order: _____
Make check or money order payable to First Agency, Inc.

This completed form and payment must be received by us prior to 9/3/09 (1/20/10 for spring term enrollment)

I hereby certify that as the full-time student applicant named above, the information contained on this enrollment is true. I understand that the effective date of my coverage under the Increased Supplemental Plan or the Catastrophic Major Medical Coverage is the date this form and premium are received by the Company.

Student
Signature: _____ Date ____/____/____

IMPORTANT: Injury resulting from practice or play of intercollegiate sports is excluded from this plan

Mail To:
First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501