



New Jersey: Enrollment for Student Accident Insurance

LAST NAME _____

FIRST NAME _____ MIDDLE INITIAL _____

MALE FEMALE DATE OF BIRTH ____/____/____
(Month/Day/Year)

STREET ADDRESS _____

CITY OR TOWN _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

NAME OF PARENT OR GUARDIAN (BENEFICIARY) **PLEASE PRINT**

All statements made on this enrollment form are true and complete to the best of my knowledge and belief.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NAME OF SCHOOL DISTRICT _____

SCHOOL NAME _____ GRADE _____

Please select the desired plan:

SCHOOL SPONSORED STUDENT ACCIDENT INSURANCE PLAN	
Premium Cost Per Year	
24-HOUR PLAN	
Students _____	
Grades Pre-K-12 <input type="checkbox"/>	\$185.00

PLEASE DO NOT SEND CASH.

ONLY CHECKS OR MONEY ORDERS WILL BE ACCEPTED.

I enclose \$ _____ **Total Premium**

PARENT'S SIGNATURE _____

TODAY'S DATE _____

Mail this form and the appropriate premium to: **RPS Bollinger, PO Box 1515, Morristown, NJ 07962.** Your canceled check is your receipt.