

Junior College Intercollegiate Sports Catastrophic Insurance Enrollment Form

Underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

General

Name of Institution Galveston College

Address 4015 Avenue Q

Street

Galveston

City

TX

State

Zip

Contracting Official Kelly Raines

Name

AD

Title

409-944-1215

Phone

Fax

E-mail Address kraines@gc.edu

Sports Census

Please enter the number of participants for every sport in the table below and add any sports that are not listed.

Note: For Track & Field, enter the maximum number of participants between indoor and outdoor to avoid double counting. For Football, enter the maximum number of participants between spring and fall to avoid double counting.

Sports	# of Sport Participants		
	Women	Men	Total
Baseball		54	54
Basketball			0
Bowling			0
Cheerleading			0
Cross County Running			0
Dance			0
Football			0
Golf			0
Lacrosse			0
Rodeo			0
Soccer			0
Softball	26		26
Student Coaches/Student Managers/Student Trainers			0
Swimming & Diving			0
Tennis			0
Track & Field			0
Volleyball	24		24
Wrestling			0
			0
			0
			0
			0
Grand Total:	50	54	104

Name of Institution:

Premium

Please select the desired benefit period and deductible combination in the table below.

Select Plan	Benefit Period	Deductible	Total Premium
<input checked="" type="checkbox"/>	Lifetime	\$25,000	\$ 3,020
<input type="checkbox"/>	Lifetime	\$35,000	\$ 2,476
<input type="checkbox"/>	Lifetime	\$50,000	\$ 1,964
<input type="checkbox"/>	10-Year	\$25,000	\$ 2,506
<input type="checkbox"/>	10-Year	\$35,000	\$ 2,055
<input type="checkbox"/>	10-Year	\$50,000	\$ 1,631

Make premium check payable to Academic HealthPlans and mail payment along with this completed form to one of the following offices:

Kansas Office:
 16201 W. 95th St., Ste. 210
 Lenexa, KS 66219
 913-815-1300
 Attn: Stephanie Williams

Salt Lake City:
 2180 South, 1300 East, Suite 450
 Salt Lake City, UT 84106
 801-412-2622
 Attn: Carol Malouf

Term of Coverage

It is understood that the effective date of coverage under this program will be either the **date requested** or the **date this form and the premium are received** and accepted by the Company, whichever is later (for a requested effective date of August 1 we must receive the enrollment form no later than October 1 of the current year). Coverage expires one year from the effective date.

Desired Effective Date _____

By _____

Date _____

Signature of Contracting Official

Stephanie Williams

Licensed Agent's Signature

13336363

License Number

Date _____