E.J. Smith Insurance Agency
Credit Card Authorization Form

Student's Name: _____

Name of College or University: _____

City: _____ **State:** _____

Coverage Start Date (Month/Year): ____ / ____ **Number of Months Being Paid For:** _____

Monthly Rate: $ _____ **x Months** _____ **= Premium Due: $** _____
(4 month minimum)

Add $5.00 Credit Card Collection Fee per transaction: ***+ $ 5.00***

Today's Date: _____ **Amount to be charged: $** _____

Name on Credit Card: _____

Credit Card Billing Address: _____

City / State / Zip: _____

Phone Number: _____

Credit Card #: ☐☐☐☐ -- ☐☐☐☐ -- ☐☐☐☐ -- ☐☐☐☐

Expiration Date: ☐☐ / ☐☐ **CCV/Security Code (on back of card):** ☐☐☐

Card Type (circle one) **Visa or Master Card or Discover**

No premium refunds are payable except when an Insured enters the Armed Forces.

I hereby authorize E.J. Smith & Associates, Inc. to charge the above credit card and apply said charges toward the payment of my insurance.

Signature of Card Holder: _____

Please mail or email this completed form & Enrollment Form to the address below:

sales@ejsmith.com

SMITH

E.J. SMITH & Associates, Inc.
899 Skokie Boulevard
Northbrook, IL 60062
847-564-3660 Fax: 847-564-3069
www.ejsmith.com

If you would like Proof of Insurance faxed to your school, complete below:

Fax #: _____ - _____ - _____ Attn: _____

ENROLLMENT FORM
Please read enrollment instructions carefully and print all information legibly.

Student's Name: _____
(First) (M.I.) (Last)

Billing Address:

_____
(Street Address) (Apt. #)

_____
(City, State, ZIP)

_____
(Phone Number)

_____
(Email Address)

Date of Birth: _____ Age: _____ Sex: _____
(Month/Day/Year)

Social Security Number: _____

Beneficiary: _____

Name of College or University: _____

City: _____ State: _____

Who Are You Enrolling?

___ Student Only ___ Student & Spouse
___ Student & Child(ren) ___ Student & Family

Dependent Information:

_____
(Spouses' or Child's name) (Social Security Number) (Sex) (Date of Birth)

_____
(Child's name) (Social Security Number) (Sex) (Date of Birth)

_____
(Child's name) (Social Security Number) (Sex) (Date of Birth)

_____
(Child's name) (Social Security Number) (Sex) (Date of Birth)

What Benefit Plan Are You Applying For?

___Plan I ___Plan II ___Plan III

Coverage Start Date: _____
(Month/Year)

Number of Months Being Paid For: _____

Premium Due: $_____

Is anyone proposed for coverage covered by any Title XIX program (such as, Medicaid)? ___ Yes ___No

If yes, list names who will be excluded from coverage.

_____

I verify that I am a registered Student of the above named school and I understand that my eligibility may be subject to verification by the school.

Signature: _____ Date: _____