WILBRAHAM & MONSON ACADEMY 2020-2021
423 Main Street, Wilbraham, MA 01095 • Phone: 413.596.6811 • Fax: 413.596.3655 • www.wma.us

STUDENT ACCIDENT & SICKNESS PLAN

Dear Parent/Guardian,

Out of concern for the health and welfare of our students, Wilbraham & Monson Academy requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by *local providers and practitioners*.

- Our health services will not accept medical insurance policies issued in a foreign country or from a company outside the United States.

To help you meet this financial responsibility, we offer a policy that will cover students during a 10-month period (Aug. 15, 2020 - June 14, 2021). This plan was designed especially for private secondary schools and meets the mandated requirements of Massachusetts law with benefits for those who do not have insurance or whose coverage is not accepted outside their geographical area. This plan will cover students anywhere in the world, *except their home country*, for a 10-month period for a premium of ($1,880) or a 12-month period (Aug. 15, 2020 – Aug. 14, 2021) for a premium of ($2,090).

INTERNATIONAL STUDENTS WHO DO NOT HAVE COVERAGE WITH A U.S.-BASED COMPANY (AS A DEPENDENT ON THEIR PARENT'S PLAN) MUST ENROLL.

If we do not hear from you, your child will be enrolled automatically, and the premium of $1,880 will be applied to the first tuition bill.

Please check the appropriate boxes below, include student's name, sign your name, date and return promptly to: rpower@wma.us or fax to 413.596.3655.

2020-2021 STUDENT INJURY & SICKNESS PLANS

1. [ ] Enroll (student) _____ in plan for:
[ ] A full 10 months (Aug. 15, 2020 - June 14, 2021 - $1,880)

2. [ ] Enroll (student) _____ in plan for:
[ ] A full 12 months (Aug. 15, 2020 - Aug. 14, 2021 - $2,090)

3. [ ] Do not enroll (student) _____ in the plan.
In making this selection, I accept full responsibility for all medical costs incurred by my child. My present in-force plan is as follows: (Please include a copy of the front and back of your insurance card)
****A COPY OF THE PRIVATE HEALTH INSURANCE CARD IS MANDATORY****

_____ _____
INSURANCE COMPANY NAME **POLICY NUMBER & PHONE NUMBER**

_____ _____
INSURANCE COMPANY ADDRESS **CITY, STATE AND ZIP CODE**

_____
SIGNATURE OF PARENT OR GUARDIAN **DATE**