UNIVERSITY of WASHINGTON

PHYSICIAN ASSISTANT APPLICATION

LONG TERM DISABILITY INSURANCE

PERSONAL INFORMATION PLEASE PRINT LEGIBLY

Name (First, Middle Initial, Last) _____ Expected Graduation Date _____

Student Number (or last 4 digits of SSN) _____ Gender: ☐ Male ☐ Female Date of Birth _____

CONTACT INFORMATION PLEASE PRINT LEGIBLY

Street Address _____ City _____ State _____ ZIP Code _____

Home Telephone Number _____ Cell Number _____ Pager Number _____

Email Address _____

SIGNATURE

I hereby request coverage under the AMA sponsored Med Plus Advantage Long Term Disability Plan for Physician Assistants issued by Standard Insurance Company. I understand that the coverage provided will be subject to the terms and conditions of the group insurance policy.

Signature _____ Date _____

PAYMENT INSTRUCTIONS AND MAILING ADDRESS

Premium coverage from July 1, 2025 through June 30, 2026 is $93.08 for year one, and $108.59 for year two.
The form and premium must be postmarked by August 31, 2025.
Please return the completed form, with check payable to "Standard Insurance MPA Program" and include "Policy #644228" to:

AMA Insurance Agency, Inc.
Attn: Finance Department
330 N. Wabash Ave.
Suite 39300
Chicago, IL 60611

PLEASE KEEP A COPY FOR YOUR RECORDS

Plan administered by
AMA Insurance Agency, Inc.
330 N. Wabash Ave., Suite 39300, Chicago, IL 60611
800.458.5736