

Shaded area for administrative purposes; do not fill in this section.

Group Name AMA-Med Plus Advantage	Division ISG	Billing Category	Date of Residency
---	------------------------	------------------	-------------------

To Be Completed By Applicant *Check all boxes and complete all sections that apply.*

Your Name (Last, First, Middle)		Your Social Security Number	Birth Date		<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State	ZIP	Phone Number
Current Medical School		Graduation Date	Resident Program		
Residency Start Date	Projected Residency Completion Date	Email Address			

Payment

Please submit a check for \$121.83 (price includes special 5% premium credit), made payable to: **Standard MPA Program**

Please mail this completed form and payment to:

Med Plus Advantage Program

Attn: Sue Farrell

AMA Insurance Agency
 515 N State Street
 Chicago IL 60654

Application and premium must be received by July 1, for a July 1 start

Future premiums will be billed annually

Coverage Information may be found at www.medplusadvantage.com or contact the Med Plus Advantage program manager at 888-627-6618

Change

Complete this section only when you wish to make a change after insurance becomes effective.

Name Change Former name _____

Other _____

Signature I verify the above information is correct. I understand that by completing this form I am applying for Long Term Disability insurance and I am responsible for paying annual premiums. **I understand that my annual premium amount will change if my coverage or costs change.**

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____