



Student Contact Information

LAST NAME		FIRST NAME (as appears on passport)		ID#
E-MAIL		PHONE		
LOCAL ADDRESS				
CITY		STATE	ZIP CODE	
VISA TYPE				

Insurance Information

NAME OF INSURANCE COMPANY	
POLICY NUMBER	COUNTRY
EFFECTIVE DATE (mm-dd-yyyy)	EXPIRATION DATE (mm-dd-yyyy)

Coverage Requirements (check each box to indicate that your coverage meets or exceeds the requirements)

- \$100,000 for each sickness or illness
- Maternity Benefits: same as sickness, pregnancy, childbirth, and complications
- \$100,000 for each accident or injury
- \$50,000 for medical evacuation to home country
- \$25,000 for repatriation of remains to home country
- Deductible (or excess fee) not more than \$500 per sickness or injury (per person)
- \$500,000 lifetime policy maximum (recommended)

Benefits must be covered to give amounts in US Dollars  
 Exclusions and limitations must be more than comparable  
 Final decisions and approvals are made by the Office of International Student Services

I certify that, to the best of my knowledge, the above information is a true and accurate reflection of my insurance coverage for summer term. I have attached a copy of my insurance card and insurance policy to this form.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

For Office Notes Only.

Date Received: \_\_\_\_\_ Insurance Waived till: \_\_\_\_\_ Initials: \_\_\_\_\_ Date entered in BEX: \_\_\_\_\_