Loyola University Maryland
Office of International Student Services
4501 N. Charles Street, HU 141
Baltimore, MD 21210
Ph: 410-617-5245; Fax: 410-617-5721

MONTESSORI SUMMER SESSION
INTERNATIONAL STUDENT HEALTH INSURANCE ACCEPTANCE/WAIVER FORM

Last Name _____ **First Name** _____ **Middle Name** _____

Email Address_____ **Phone Number**_____

Loyola Student ID_____

Instructions: All international students who attend Loyola University Maryland are required to have health insurance.

- Complete **Section A** if you have health insurance that is accepted in the United States and you do not wish to purchase health insurance through Loyola University. A copy of your health insurance card must be submitted along with this form, showing validity through the summer session.
- Complete **Section B** if you wish to purchase health insurance through Loyola University.

Loyola University Maryland will not issue a Form I-20 for an F-1 student visa unless this form and all supporting documentation is received. PLEASE PRINT CLEARLY.

SECTION A:

Name of insurance Company/Group Plan _____

Policy Number _____ Expiration Date _____

I hereby testify that this insurance policy fulfills the following conditions:

- It provides at least $50,000 per illness or accident per year in coverage;
- The deductible does not exceed $500.00 per accident or illness;
- The policy is valid while I will be attending classes at Loyola University Maryland. If it expires, I will renew the policy so as to ensure the continuance of health insurance coverage. My signature on this form indicates agreement to this condition.
- The cost of medical evacuation ($10,000) and repatriation ($7,500) are included **OR**
- Full responsibility for evacuation/repatriation expenses will be undertaken by me or my sponsor.

In order to be waived out of purchasing health insurance through Loyola, it is necessary to include a copy of your current health insurance card.

Student Signature _____ Date _____

SECTION B:

Please enroll me in the Loyola University Maryland AETNA Health Plan. A completed application and check made payable to AETNA, Inc. are enclosed.

Student Signature _____ Date _____