LOYOLA UNIVERSITY
HEALTH INSURANCE ACCEPTANCE / WAIVER FORM
FOR INTERNATIONAL EXCHANGE STUDENTS ONLY

Instructions: All international exchange students who attend Loyola University must show proof of health insurance. Complete **Section A** if you do not wish to purchase the Loyola University Student Health Insurance. Complete **Section B** if you do wish to purchase Loyola's health insurance plan. Loyola University will not issue an I-20 student visa form unless this form and necessary documentation is received along with the application.

Return this form with your completed Loyola University Application for admission to: **Office of International Programs, Loyola University, 4501 North Charles Street, Baltimore, MD 21210, USA**

ALL STUDENTS COMPLETE THIS SECTION:

Student Name_____
Last Name *First Name* *Middle Initial*

Phone Number 011-_____ Email _____
Country Code City Code Home Number

SECTION A:

Name of Insurance Company/Group Plan_____

Policy Number_____ Expiration Date_____

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

- ☐ (a) It provides at least $50,000 per illness or accident per year in coverage;
- ☐ (b) The deductible does not exceed $500.00 per accident or illness;
- ☐ (c) The policy is valid until January 1 if I will be attending classes in the Fall semester and/or until August 15 if I will be attending classes in the Spring semester. If it expires before this date, I will renew the policy so as to ensure the continuance of health insurance coverage for the full academic year. My signature on this form indicates agreement to this condition.
- ☐ (d) The cost of medical evacuation ($10,000) and repatriation ($7,500) are included

Student Signature_____ Date_____

Parent/Guardian/Sponsor Signature_____ Date_____
(If student is under the age of 18 years.)

SECTION B:

Please enroll me in the Loyola University Health Plan for the semester(s) that I am attending Loyola University. I understand that my signature authorizes Loyola University to bill me for insurance coverage. I understand that I will be billed and covered for only the semester(s) that I have initialed below. I have read and accept the contents of the enclosed Loyola University Student Health Insurance Plan Brochure.

SPRING 20_____FALL 20_____ *(Please indicate the semester(s) you require insurance.)*

Student Signature_____ Date_____

Parent/Guardian/Sponsor Signature_____ Date_____
(If student is under the age of 18 years.)

Loyola Identification Number_____
(To be filled in by Loyola Official)