



**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 Maryland. 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 plan for Loyola University Maryland.

**Loyola University Maryland will not issue a Form I-20 for an F-1 student visa until this form and all supporting documentation are 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 this health insurance card.**

I have included a copy of my health insurance card with this form.

***I hereby testify that, should it be necessary in the event of a health emergency, I will incur any/all additional costs that may not be covered by my current health insurance plan.***

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION B:**

- Please enroll me in the Loyola University Maryland Health Insurance Plan. Information about this plan can be found a <https://www.loyola.edu/departments/student-health/health-insurance/graduate-info>

Student Signature \_\_\_\_\_ Date \_\_\_\_\_