

2008-2009

# HEALTH INSURANCE FORM

This form must be returned to the Student Health Center no later than August 1st. Law and International students who fail to return this form by the deadline date will be automatically enrolled and billed for the University endorsed accident and health insurance plan.



Return by August 1, 2008 to:

Student Health Center  
204 W. Washington Street  
Lexington, VA 24450  
PHONE: (540) 458-8401  
FAX: (540) 458-8404  
studenthealth@wlu.edu

By University policy, all students are required to provide evidence of adequate health and hospitalization insurance coverage to supplement the medical care provided by the University. This coverage may be in the form of an individual policy already in effect, inclusion in a family policy, or enrollment in the optional group program of accident and health insurance offered to all Washington and Lee students. **(This form must be returned to the Student Health Center no later than August 1, 2008. Law and International students who fail to return this form by the deadline date, will be automatically enrolled and billed for the University endorsed accident and health insurance plan.)**

## Student Information

Student _____ Last First Middle	Class Year _____ <input type="checkbox"/> UG <input type="checkbox"/> LAW
Cell Phone: (____) _____ - _____	Date of Birth ____/____/____ M D Y
	SSN _____ - _____ - _____

## Contact Information

Father/Guardian	Mother/Guardian
Name _____	Name _____
Address _____	Address _____
City _____	City _____
State _____ ZIP _____	State _____ ZIP _____
Home Phone (____) _____ - _____	Home Phone (____) _____ - _____
Work Phone (____) _____ - _____	Work Phone (____) _____ - _____
SSN _____ - _____ - _____ DOB ____/____/____	SSN _____ - _____ - _____ DOB ____/____/____

## Insurance Information (Please attach a copy of your insurance card (front & back).)

Policyholder _____	Group Policy # _____	Group Certificate # _____
Insurance Company's Name _____	Phone # _____ - _____ - _____	
Address _____	City _____	State _____ ZIP _____ - _____
Do you have dental coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please attach a copy of your dental card.)	
Do you have prescription coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please attach a copy of your prescription card.)	
Do you need a PCP referral see a specialist?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, what is the PCP's name? _____ PCP's Phone (____) _____ - _____)	
Do you need pre-authorization for x-rays or off-campus consultation?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, who is to be contacted? e.g. Insurance Co., PCP, etc.) Name _____ Phone (____) _____ - _____	

I understand that the University is not responsible for any uninsured expenses in the event of accident or sickness of a student. I will notify Washington and Lee University immediately upon any change in the stated insurance information.

I choose to enroll/have my son/daughter enrolled in the Student Accident & Health Insurance Policy for 2008-2009 for students at Washington and Lee University. The student will be enrolled in the plan and billed by the University for this policy coverage.

I choose **NOT** to enroll/have my son/daughter enrolled in the 2008-2009 Student Accident & Health Insurance Policy for students at Washington and Lee University, and have completed the insurance information above.

Signature of Student \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (If over age 18)

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ (Required if student is under 18)