I N S U R A N C E F O R M

NOLS requires that all students have their own health insurance. Please complete this form so that we will have information concerning your insurance coverage. It is your responsibility to make sure your insurance will cover you for the duration of the course. The student will be responsible for obtaining any necessary pre-admission review.

Student's Name _____ Course Code _____

Birth Date (dd/mm/yyyy) _____ Application ID # _____

No One Will Go On A Course Without Health Insurance Coverage. If you do not already belong to a regular health program, we suggest a short-term policy, which you may buy from your local insurance agent. Non- U.S. citizens, please indicate your primary health coverage and any out-of-country travel insurance.

Name and Address of Person Under Whose Name the Policy is Carried

Name _____ Street Address _____

City, State/Province _____ Zip/Postal _____ ( ) Phone _____

Insurance Company Information

Name _____ Policy Number _____

Group Number _____ Agreement Number _____

Address Where Claims Must Be Submitted

Name _____ Street Address _____

City, State/Province _____ Zip/Postal _____ ( ) Phone _____

If Group Insurance, Give Name of Group (employer, union or association through which the student is insured)

Name _____

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