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 Name ______________________ AMWE 04/22/2012

Birth Date (dd/mm/yyyy) ______________________ Application ID # *(Office Use Only)*

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 Date of Birth

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