

# 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

\_\_\_\_\_  
USNA  
Course Code

\_\_\_\_\_  
Birth Date (dd/mm/yyyy)

\_\_\_\_\_  
Application ID # (NOLS Internal 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 (Only include if you are **NOT** on TRICARE)

\_\_\_\_\_  
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

