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.

_____ _____WFLE 01/29/2012_____
Student Name Course Code

_____ _____
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