

Returning

New

Health Insurance Enrollment/Waiver Form

ALL STUDENTS CARRYING TWELVE OR MORE CREDIT HOURS ARE REQUIRED TO HAVE HEALTH INSURANCE. STUDENTS MUST SECURE COVERAGE THROUGH LBC OR PROVE COVERAGE THROUGH A PARENT, SPOUSE OR EMPLOYER.

Student Name: _____ Number of credits: _____
(Please PRINT full name)

Date: _____ Birth Date: _____ Social Security #: _____

INSTRUCTIONS

- If you have insurance coverage:
 - Complete section A and section C (if applicable)
 - Attach a copy of the front and back of your insurance card to this form
- If you **do not** currently have health insurance coverage, complete section B and section C (if applicable).
- Send completed form to:
Lancaster Bible College
ATTN: BUSINESS OFFICE
PO Box 83403
Lancaster, PA 17608-3403

SECTION A

I have health insurance coverage through my parent, spouse or employer.

Insurance Provider: _____ Phone #: _____

Insured's Name: _____ Group #: _____ Plan #: _____

Claims should be sent to: _____
(Name)

(Street)

(City, State, Zip)

This policy covers intercollegiate athletics Yes No

SECTION B

I hereby request to be enrolled in the student health insurance plan of Lancaster Bible College.

Student Coverage Only
\$500-Fall Semester
\$700-Spring Semester

Family Coverage (Please include names, social security numbers
and birthdays on the back of this sheet)
\$2,250-Fall Semester
\$3,150-Spring Semester

SECTION C

STUDENTS UNDER 18 YEARS OF AGE MUST HAVE THIS STATEMENT SIGNED BY A PARENT OR GUARDIAN.

I hereby consent and authorize the hospital and doctor to conduct examination treatment and operations which are necessary for my son/daughter. I also certify that I will be responsible for charges not paid by the insurance company.

Parent Name: _____ Parent Telephone #: _____

Parent Street Address: _____

City: _____ State: _____ Zip: _____

Parent Signature: _____ Date: _____