

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: \_\_\_\_\_ Student ID #: \_\_\_\_\_

### 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: \_\_\_\_\_