

LSU HEALTH SCIENCES CENTER  
STUDENT ACCIDENT AND SICKNESS PLAN  
SCHOOL OF MEDICINE

TERM---2009-2010

As part of the acceptance criteria to LSUHSC, I agreed to purchase and maintain adequate health insurance for the duration of my enrollment. I understand that LSUHSC endorses a Blanket Accident and Sickness Plan for LSUHSC students. I also understand that **IT IS MY RESPONSIBILITY (and for my protection)**, to either purchase the LSUHSC plan or to provide proof of alternate insurance.

I am fully aware the Louisiana State University Health Sciences Center is not responsible for interpretation or review of the policy information presented, or any expenses resulting therefrom. I agree to be responsible for advising my department of LSUHSC (in writing) of any lapses or cancellations of this policy during any semester for which I am enrolled.

NAME: \_\_\_\_\_  
Please type or print

SSN: \_\_\_\_\_

SIGN EITHER SECTION I OR II – NOT BOTH

SECTION I – AUTHORIZATION TO PURCHASE LSUHSC HEALTH INSURANCE

I hereby authorize the LSUHSC Accounting Office to assess the appropriate health insurance premium for the **2009/2010 Annual Term**. By paying half of the premium during the **Fall registration**, I understand that the remaining balance will be assessed during the **Spring registration**.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

SECTION II – STUDENT INSURANCE WAIVER

I am insured through my work (to include employer, spouses employer or parent) for the entire **2009-2010** academic year. In addition to listing the name and phone number on my insurance company below, **I HAVE APPENDED A XEROX COPY OF BOTH SIDES OF MY INSURANCE I.D. CARD.**

**I understand that if the required copy of my insurance I.D. card is not appended to this form, LSUHSC has the full authorization to assess the semester premium during registration.**

COMPANY NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date