



LSU HEALTH NEW ORLEANS (HEALTH SCIENCES CENTER)
STUDENT ACCIDENT AND SICKNESS PLAN

TERM---2017/2018

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

EMPLID NUMBER: _____

SIGN EITHER SECTION I OR II – NOT BOTH

SECTION I – AUTHORIZATION TO PURCHASE LSUHSC HEALTH INSURANCE

I hereby authorize the LSUHSC Bursar Operations Office to assess the appropriate health insurance premium for the **2017/2018 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 **2017-2018** 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