



STUDENT HEALTH REQUEST FOR INFORMATION

Name of College/University: _____

Address: _____

_____ City _____ State _____ Zip

RESPONSIBLE SCHOOL OFFICIAL:

Name: _____ Date: _____

Title: _____ Phone: _____

TYPE OF PLAN: (Check all applicable. Please send a brochure of your present Student Health Plan.)

- | | |
|---|---|
| <input type="checkbox"/> Mandatory Accident | <input type="checkbox"/> Mandatory Sickness |
| <input type="checkbox"/> Voluntary Accident | <input type="checkbox"/> Voluntary Sickness |
| <input type="checkbox"/> Waiver Accident | <input type="checkbox"/> Waiver Sickness |
| <input type="checkbox"/> Other (Describe) _____ | <input type="checkbox"/> Other (Describe) _____ |

Current Year Number of Students in College	Men _____	Women _____
Current Year Number of Students on Insurance Plan	Men _____	Women _____
Current Year Number of Resident Students Total	Men _____	Women _____

LOSS EXPERIENCE INFORMATION: (If benefits were changed in the past 3 years, please send a copy of the brochure for the appropriate year(s).)

Year	Total Premiums	Paid Claims	Number of Insured Claimants
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____
_____	\$ _____	\$ _____	_____

PREMIUM RATES: (Indicate rates charged for the current and past three years.)

Year				
Student	\$ _____	\$ _____	\$ _____	\$ _____
Student/Spouse	\$ _____	\$ _____	\$ _____	\$ _____
Student/Spouse/Child(ren)	\$ _____	\$ _____	\$ _____	\$ _____

HEALTH SERVICE INFORMATION:

Do you have an Infirmary? Yes No Dispensary? Yes No Number of Beds? _____

What services are provided FREE of charge to students? _____

Date quote needed _____