



INSURANCE INFORMATION

There are 2 options available for International Student Insurance coverage. Please read carefully and choose Option 1 below or Option 2 on the reverse side of this form. Do not choose Option 2, if the policy does not meet the requirements listed.

Student Name: _____ Birthday: _____ Gender: _____

Natural Parents or Guardian Full Names _____

Student Address in USA _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

_____ **Option 1: School International Insurance* Not for American Citizens**

Coverage: You may purchase 24-hour coverage (except home country) while outside home country, including travel directly to and from country of residence and the United States.

Limits:*	Lifetime Maximum Major Medical Benefit:	No Maximum
	Annual Maximum per person, per year	\$ 1,000,000.00
	Emergency Medical Evacuation	Unlimited
	Repatriation of Remains	Unlimited
	Office visit Co-pay \$20.00 (100% Participating Doctor, 80% non-participating)	
	Emergency Room & Inpatient \$100.00 copay (100% coverage)	

*** Read brochure: other benefits and limits available upon request; subject to change**

_____ 12 months August 1st - July 31st \$ 1,280.00

_____ 10 months August 1st - May 31st \$1,070.00

FILL OUT FOR SCHOOL INSURANCE AND RETURN

(Make check out to) **CHRISTIAN UNIFIED SCHOOLS OF SAN DIEGO, Inc.**
For INTERNATIONAL STUDENT HEALTH INSURANCE
The LEWER AGENCY, Inc. Insured by: GBG Insurance Limited

Use **BLACK** ink
Use **BLOCK** letters

Enrollment Year 2019-2020

Period of Coverage: # of Months _____ from _____

Type of payment: Cash _____ Check _____ Wire _____ Amount Received _____ Date Received _____

NOTICE TO Student: Coverage will be effective the date the correct premium is received by the Company or a representative of the Company or the effective date of the coverage period, whichever is later, unless or otherwise stated in the Master Policy.



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_____ **Option 2: Family purchased International Medical Insurance valid in the United States must be of equivalent value to school offered policy. American citizens must use this option.** Travel Insurance is not an acceptable form of health insurance.

All F1 visa students are required to purchase health insurance. You will be billed for the insurance at the beginning of each school year. Students who request a waiver of the mandatory insurance must demonstrate that they have comparable insurance coverage. To petition for a waiver, students must follow the procedures outlined below. A new waiver form must be completed each school year. For questions regarding this waiver request form or the insurance policy for F1 visa students, please contact the student advisor in the international student office.

School Health Insurance Waiver Request Form Christian Unified Schools of San Diego International Students

School Year Dates _____

Student Name: _____ Birthday: _____

Parents/Guardian Full Names: _____

Parent/Guardian Home Phone: _____ Parent/Guardian Cell phone: _____

Please provide the following information that your policy MUST provide:

Name of Insurance Company: _____ Policy Number: _____

In case of emergency Company Address: _____

In case of emergency Company Phone: _____

Effective date of coverage: Starting date _____ Ending/expiration date _____

Maximum dollar coverage for each illness or injury (minimum \$1,000,000) _____

Annual Maximum \$1,000,000(consecutive 12 months) _____

Copayment \$20 for office visit (100% for PPO, 80% non-PPO) _____

Medical evacuation benefit (unlimited) _____

Repatriation benefit (unlimited) _____



INSURANCE INFORMATION

Attach a copy of the following, in English:

1. **Covered Services** in the form of a copy of your health insurance plan summary
2. **Proof of coverage** in the form of insurance card with the student's name and effective dates noted. Coverage must be for the length of time the student is attending school.

You will be notified by email if the waiver is accepted. If denied you will automatically be billed for the Lower Agency policy before the student begins class.

I certify that all the information provided on this form refers specifically to the student whose name appears above on the "Student" line and is true and correct. I understand that my student must have full coverage while a student at Christian Junior/Senior High School and will keep insurance coverage valid and notify CHS of any changes in company or policy.

Signature Parent or Designated Guardian

Date