



STUDY ABROAD PROOF OF U.S.
HEALTH INSURANCE FORM

I, the undersigned, understand that I am required to maintain an effective health insurance plan in the U.S. while I am abroad. The Study Abroad worldwide health insurance policy covers students and faculty ONLY while they are outside of the United States, and the policy terminates upon return to the United States.

I hereby verify, that I am covered through the below-indicated medical insurance plan in the United States. Claims not covered by this insurance policy will not be covered by Arkansas State University. That includes, but not limited to, claims for: loss of property, theft of property, damage of property, etc.

NOTICE: THE FOLLOWING INFORMATION IS REQUIRED OF ALL STUDENTS WHO PARTICIPATE IN A STUDY ABROAD PROGRAM THROUGH A-STATE

Name: _____

Student ID #: _____

Program: _____

Health Insurance Company: _____

Policy Number: _____

**Attach a copy of your insurance card, front and back, to this form*

In an emergency, please notify (include name, address, phone, email address):

Personal Physician: _____

Physician's Address and Phone Number:

Identify any past or current medical conditions and allergies knowledge of which may be necessary to facilitate your participation in the program and/or for effective medical treatment:

Current Medications (list all): _____

The information on this form is an accurate description of my health currently and is accurate to the best of my knowledge.

Signature

Date