ARKANSAS STATE UNIVERSITY

STUDY ABROAD INSURANCE ENROLLMENT FORM

All students and participants in A-State programs are required to enroll in the student worldwide health insurance plan for the period of time they are abroad.

Please select the section that corresponds to your program.

You will be automatically enrolled in the A-State Study Abroad Insurance if you do not complete and submit this form to the Study Abroad Office. If you are Study Abroad through ISEP or a third party provider and are getting Study Abroad health through ISEP or the third party provider, you must complete the waiver portion of this form.

Student Name: _____Student ID #: _____Date of Birth: _____

Program Name: _____

Program Start Date: _____End Date: _____

- o I am participating in Study Abroad, through an A-State Bilateral Exchange or Affiliate Partner.
  I will enroll in the A-State mandatory Study Abroad health insurance and understand the insurance charge will be applied to my A-State student account.

- o I am going abroad for an internship, a service learning project, independent study, or conference.
  I will enroll in the A-State mandatory Study Abroad health insurance. I understand the insurance charge will be applied to my A-State student account.

- o I am participating in an A-State Faculty-Led Program.
  I will enroll in the A-State mandatory Study Abroad health insurance. I understand the insurance charge will be applied to my A-State student account.

- o I am participating in an A-State Faculty-Led Program.
  Insurance is provided by a third party provider. I will enroll in the provider's Study Abroad health insurance.

_____

Signature Date

Waiver

- o I am participating in Study Abroad through ISEP or a third party provider.
  I am getting Study Abroad insurance through ISEP or a third party provider. I certify that I will maintain enrollment in this medical insurance plan throughout the term of the program. I understand that neither A-State nor its Study Abroad Office, or Program Leader will be responsible for my medical expenses. I acknowledge that I am legally responsible for all medical and insurance expenses incurred by myself. I certify this information is true and accurate.

_____

Signature Date