

**LSU HEALTH SCIENCES CENTER  
STUDENT ACCIDENT AND SICKNESS PLAN**

**TERM---2019/2020**

As part of the acceptance criteria to LSUHSC, I have 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 thereof. 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 clearly)

EMPLID NUMBER: \_\_\_\_\_

**SIGN EITHER: SECTION I OR SECTION 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 **2019/2020 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, spouse’s employer or parent) for the entire **2019-2020** 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 HEALTH 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.**

INSURANCE CO. NAME: \_\_\_\_\_ PHONE # \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date