

## EMERGENCY CONTACT & INSURANCE INFORMATION FORM INTERNATIONAL STUDENTS

ACADEMIC YEAR 2010-2011

I accept the Mercyhurst sponsored Highmark PPO Blue Health Insurance Plan with the following coverage:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Individual coverage<br>\$1,224.00 Annual<br>\$416.00 per Trimester | <input type="checkbox"/> 2-Person coverage<br>\$3,185.00 Annual<br>\$1,070.00 per Trimester | <input type="checkbox"/> Family coverage<br>\$3,804.00 Annual<br>\$1,277.00 per Trimester |
|---|---|---|

Please fill out this form completely and legibly, sign and return this form and accompanying payment to:  
 Mercyhurst College, Attn: Anita Higgins, Egan Hall 323, 501 East 38<sup>th</sup> St., Erie, PA 16546

<b><u>STUDENT INFORMATION:</u></b>	
Name _____	Student ID# _____
Date of Birth _____ SSN _____	Sport (if applicable) _____
College Address _____	Campus Phone _____
Home Address _____	Home Phone _____
City _____ State _____ Zip _____	Country _____
<b><u>PARENT INFORMATION:</u></b>	
Father/Guardian Name _____	Mother/Guardian Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone (____) _____	Phone (____) _____
Employer _____	Employer _____
<b><u>INSURANCE INFORMATION:</u></b>	
<b><u>PRIMARY INSURANCE INFORMATION</u></b>	<b><u>SECONDARY INSURANCE INFORMATION</u></b>
Name of Policyholder _____	Name of Policyholder _____
Policyholder SS# _____	Policyholder SS# _____
Policyholder Date of Birth _____	Policyholder Date of Birth _____
Insurance Company Name _____	Insurance Company Name _____
Plan Name/Type _____	Plan Name/Type _____
Group Number _____	Group Number _____
Policy / ID Number _____	Policy / ID Number _____
Claims Mailing Address _____	Claims Mailing Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Country _____	Country _____
Ins. Co. Phone (____) _____	Ins. Co. Phone (____) _____
<b><u>CHECK ONE AND SIGN BELOW: (It is recommended that International Students choose Option "B")</u></b>	
<p>A. _____ I hereby validate that the insurance information I have provided above is correct to my knowledge, currently valid, and provides coverage for medical expenses incurred in the United States of America. If there is a material change in the coverage or expiration of coverage, I agree to notify Mercyhurst College of this development and update the insurance information I have on file with Mercyhurst College.</p>	
<p>B. _____ My son/daughter is not covered under any group insurance (or the insurance we have does not cover out of country expenses), but I am willing to pay for coverage under the Highmark Blue Cross/Blue Shield PPO Blue plan offered through Mercyhurst College. I understand that I must enroll and purchase this plan prior to participation and pay all premiums for the entire year during which the insurance is provided.</p>	
<p>I hereby authorize Mercyhurst College and it's affiliated and contracted insurance companies, brokers and administrators to investigate the validity of the insurance information provided by the student. A photo static copy of this authorization shall be deemed as effective and valid as the original.</p>	
Signature of parent _____	Date _____
Signature of student _____	Date _____

**\*\*Please provide a signed copy of the Acknowledgement of Insurance Requirements form with all required documentation\*\***

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS FOR  
INTERNATIONAL STUDENTS

I, \_\_\_\_\_, attest that I have insurance coverage under a current,  
(Student name)

in-force insurance policy for medical expenses that occur during my enrollment at Mercyhurst College and that it meets or exceeds the following requirements:

- Offers at least 80% coverage for in-patient and out-patient medical services
- Includes mental health benefits
- Has a deductible that does not exceed \$500
- Does not contain any language limiting coverage on pre-existing conditions
- Lifetime maximum of at least \$1,000,000

If my health coverage does not meet the criteria established above or if I do not provide the documents listed below as proof of my current coverage, I agree that I will remain on the Mercyhurst College Student Health Plan and pay the required premiums.

If there is a material change in coverage or expiration of coverage, I agree to notify Mercyhurst College of this development and update the insurance information I have on file with Mercyhurst College.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**THIS FORM MUST BE SIGNED AND RETURNED TO MERCYHURST COLLEGE BY  
August 31, 2010.**

**Accompanying this form must be the following documentation:**

- Copy of the front and back of the current insurance card
- Written proof from the insurance company in English that you are covered in the United States
- A completed Contact and Insurance Information form

**Return to:**

**Mercyhurst College  
Attn: Anita Higgins  
Egan Hall 323  
501 East 38<sup>th</sup> Street  
Erie, PA 16546**