LSU HEALTH SCIENCES CENTER
STUDENT ACCIDENT AND SICKNESS PLAN

TERM---2024/2025

As part of the acceptance criteria to LSUHSC, I agree to purchase and maintain adequate health insurance for the duration of my enrollment. I understand, LSUHSC endorses a (Blanket Accident and Sickness Plan) for LSUHSC students. I also understand, it is my responsibility and for my protection, to either purchase the Blue Cross Blue Shield of Louisiana (BCBSLA) health plan offered by LSUHSC or to provide proof of comparable major medical health insurance coverage.

I am fully aware the (Louisiana State University Health Sciences Center) is not responsible for the interpretation or the review of the policy information presented, or any expenses resulting there from.

I agree to be responsible for advising my department of LSUHSC (in writing) of any lapses or cancellation of this policy during any semester for which I am academically enrolled.

NAME: _____

EMPLID #: _____

SIGN EITHER SECTION I OR II – NOT BOTH

SECTION I – AUTHORIZATION TO PURCHASE LSUHSC HEALTH INSURANCE

I hereby authorize LSUHSC-Bursar Operations to assess the appropriate health insurance premium for the **2024/2025 Academic Year**. I agree to pay the semi-annual premium by the first day of class per the university catalog. I understand that the premium will be added to my student fee bill in the Fall Semester for coverage July 1st to December 31st & added again in the Spring Semester for coverage January 1st - June 30th. (For incoming Summer students, the health insurance premium is prorated as coverage (May 1st – June 30th)for the remainder of the academic year).

_____ _____

Signature Date

SECTION II – STUDENT INSURANCE WAIVER

I am insured through my employer, spouse's employer, or parent for the entire **2024/2025-Academic Year**. In addition to listing the name and phone number on my insurance company below, I HAVE APPENDED A COPY OR SCAN OF BOTH SIDES OF MY INSURANCE I.D. CARD.

I understand, 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 health insurance premium during registration.

Insurance Name: _____ Phone #: _____

_____ _____

Signature Date

Revised 04/26/2024