

**University of Montana —** Academic Enrichment

Davidson Honors College 002 Missoula, MT 59812 Phone: 406-243-2278 Fax: 406-243-6194 Email:studyabroad@umontana.edu

**Student Insurance Coverage Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_ /\_\_\_\_\_ /19\_\_\_\_\_ Gender: M/F

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Host Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete and return this form with a photocopy of your insurance identification card(s) to** **studyabroad@umontana.edu**

All students participating in UM-sponsored study abroad programs are required to maintain health and accident insurance coverage throughout the entire study abroad period. UM's minimum coverage requirements are as follows:

• Medical Expense Benefit: $250,000

• Medical Evacuation: $150,000

• Repatriation: $15,000

**For information on how to meet these requirements, please visit the** [**student insurance page**](http://www.umt.edu/academic-enrichment/education-abroad/um-students/once-accepted/student-insurance.php)**.**

This is to certify that I shall be covered by a health and accident insurance policy that meets the above minimum requirements for the duration of my stay abroad as a participant in the above-named program, and that I will be covered for travel to and from the study site.

**Insurance provided through (list all applicable policies):**

Insurance company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coverage Dates: from\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coverage Dates: from\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If enrolling in the HTH policy, please provide the following information along with your payment (we accept cash, credit, check or money order made payable to the University of Montana):**

HTH Comprehensive policy

Desired Dates of Coverage: from\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_

 Applicant's Signature Date

 Parent/Guardian Signature (if student is under 18) Date