INSURANCE FORM

NOLS requires that all students have their own health insurance. Please complete this form so that we will have information concerning your insurance coverage. It is your responsibility to make sure your insurance will cover you for the duration of the course.

Student's Name _____ Course Code _____

Birth Date (dd/mm/yyyy) _____ Application ID # _____

Please Attach a Photocopy of Your Insurance Card.

NAME AND ADDRESS OF PERSON UNDER WHOSE NAME THE POLICY IS CARRIED

Name _____ Street Address _____

City, State/Province _____ Zip/Postal _____ Phone _____ Date of Birth _____

INSURANCE COMPANY INFORMATION

Name _____ Policy Number _____

Group Number (if you have one) _____ Agreement Number (if you have one) _____

ADDRESS WHERE CLAIMS MUST BE SUBMITTED

Name _____ Street Address _____

City, State/Province _____ Zip/Postal _____ Phone _____

IF GROUP INSURANCE, GIVE NAME OF GROUP (EMPLOYER, UNION OR ASSOCIATION THROUGH WHICH THE STUDENT IS INSURED)

Name _____