International Student Service Office
Email: international@lamar.edu

DEPENDENT HEALTH INSURANCE AGREEMENT

Student ____ LUID ____________________

Dependent: ____ Relationship ______________

Dependent: ____ Relationship ______________

Dependent: ____ Relationship ______________

Effective May 23, 2013, F-2 dependents will no longer be required to purchase health insurance

While we strongly recommend AHP as your dependent(s) health care provider, you now have the option of choosing a more affordable health insurance plan that is more cost efficient and will meet your health insurance needs.

As a condition of this agreement, you are required to abide by the following:

- ‡ q 5 H

  uired to submit proof of health insurance coverage to the 2 I I L F H R I , Q W H U Q D W L R Q D O 6 W X 3 U R J U D P V
  D Q G 6 H U Y L F H V (2 , 6 3 6) prior to registration each academic semester.
- ‡ Required to notify the 2 , 6 3 6 immediately if the health insurance is cancelled or terminated for any reason.
- ‡ 5 H T X L U H G W R S X U F K D V H K H D O W K L Q V X U D Q F H Z L W K / 8 • V K H D O W K L
  health insurance is canceled or terminated.

I understand that by signing this form, I agree to the terms and conditions of this agreement. I also understand that this agreement applies only to my dependent(s) inside the US; therefore I am U H T X L U H G W R S X U F K D V H K H D O W K L Q V X U D Q F H F R Y H U D J H I R U P \ V H O I Z L
provided.

Date: ____________________

Student: ____ Date: ____________________