EDUCATION ABROAD PROGRAM
SUMMER SESSIONS
INSURANCE DECLARATION

NAME:

ADDRESS:

PHONE:
FAX:
E-MAIL:

I will be attending UC Berkeley Summer Session _________ (A, B, C, D or E).

I will be in the US from _________________ (date) to ________________(date).

Name of Insurance Provider: ______________________________________
(If not enrolled in a group plan through the study center, attach copy of plan and proof of enrollment.)

Declaration statement:

I understand I am fully responsible for my own health insurance coverage during the UCB Summer Sessions. My health insurance policy meets all of the following minimum requirements:

- My policy covers all medical and hospital costs, or provides me with a minimum of $50,000 (U.S.D.) for each accident or illness, has a deductible of $500 or less, and covers at least 75% of hospital and physician costs.

- My policy is covers the entire study period as defined above.

I certify that the statements on this form are correct.

Signature:        Date:

NOTE: Remember to bring with you a full description of the health benefits and an identification card giving the period of validity and telephone number of a U.S. contact person.