Return by July 31 to:
Student Health Center
204 W. Washington Street
Lexington, VA 24450
Fax: (540) 458-8404
studenthealth@wlu.edu
Phone: (540) 458-8401

WASHINGTON AND LEE UNIVERSITY

Lexington, Virginia 24450-2116

HEALTH INSURANCE INFORMATION FORM

This form is to be submitted at enrollment, and updated whenever there are changes to your health insurance information.

Student Information

Name _____ Class Year _____ ☐ UG ☐ LAW
Last First Middle

Cell Phone: _____-_____-_____ Date of Birth: _____/_____/_____ ☐ Male ☐ Female ☐ Other
M D Y

Washington and Lee University requires all full-time students to carry health insurance. You have the option of purchasing a Student Health Insurance Plan offered to all full-time students. **All international students** will be enrolled in the Student Health Insurance Plan offered through the University. You may review the policy brochure and apply for coverage or waive this coverage on-line at https://rcmdstudentbenefits.com/wlu/.

☐ **I plan to ENROLL in the Student Health Insurance Plan offered to all full-time students.**

If you wish to waive the Student Health Insurance Plan offered through the University you must supply information about your current health insurance plan: policyholder's name and contact information, ID and policy number, name and address of the insurance carrier (the insurance plan MUST have a U.S. address), the phone number for claims service; and answer the questions below about your plan.

☐ **I plan to WAIVE the Student Health Insurance Plan as I am covered by the following health insurance plan:**

Policyholder Information

Name _____
Address _____
City _____
State _____ ZIP _____
Phone (_____)_____-_____

Name _____
Address _____
City _____
State _____ ZIP _____
Phone (_____)_____-_____

Insurance Information

Please attach a copy of all insurance cards (front & back)

Policyholder Name _____ ID# _____ Group # _____
Insurance Company's Name _____ Phone # _____-_____-_____
Address_____ City _____ State _____ ZIP _____-_____
Is this a state Medicaid plan? ___ No ___ Yes If yes, which state? _____
Is this an HMO plan? ___ No ___ Yes If yes, please request guest membership in Virginia under your plan.

Authorization and Consent for Release of Information and Assignment of Benefits for Insurance Billing

- I hereby authorize and request Washington and Lee University to submit necessary information, including information from my health record, to my health insurance plan for the purpose of filing and processing claims for services provided at the Student Health Center.
- I further authorize payment for all such covered services and health insurance benefits to be made directly to Washington and Lee University.
- If my insurance company makes payment to me instead of directly to Washington and Lee University, I authorize the University to collect such payment from me by placing a charge on my University account, for which I am financially responsible.
- I understand that if I want to ensure that Explanation of Benefits statements are sent directly to me, the insured (rather than to the policyholder), I am responsible for contacting my health insurance plan to make that request.
- A copy of this authorization and consent may be used in place of the original and will remain in effect until revoked by me in writing.

_____ _____
Student Signature (if age 18 or older) Date