

LMU-DCOM

Student Health Insurance Enrollment Form

Policy Number 2009-611-1 Class# _____ School ID# _____

Group Name: Lincoln Memorial University-DeBusk College of Osteopathic Medicine (LMU-DCOM)

Student name:

Last name First Name MI Jr. Sr. etc

Social Security Number: _____ - _____ - _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of birth(mm/dd/yyyy) _____ Male Female

E-mail address: _____

.....

.....

Enrolling in Medical Coverage

Waiving Medical Coverage, Hard waiver already approved.

.....

Have you had continuous health coverage for the past 12 months? _____

If no, what are the dates of most recent coverage? Beginning _____, Ending _____

Student Signature: _____

Date: _____ Phone number: _____

.....

Office use only: Annual

Other (for mid-year enrollments) Coverage effective date: _____

Qualifying event: _____ Event date: _____

New enrollment: _____ Event date: _____

Continuation coverage: _____ Event date: _____ Term date: _____

.....

PLEASE SUBMIT CERTIFICATE OF CREDITABLE COVERAGE FROM PRIOR INSURANCE BY AUGUST 15TH. FORMS CAN BE FAXED TO 423-869-7172 ATTN: AMY ARNOLD, E-MAILED TO AMY.ARNOLD@LMUNET.EDU, OR DROPPED BY THE DCOM ADMISSIONS OFFICE ROOM #109.