BRYN ATHYN
COLLEGE

Health Insurance Update Form

Name:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/DAY/YEAR)

We request that returning students submit insurance updates yearly by August 1st.

STUDENT'S CURRENT HEALTH INSURANCE PLAN:

Please select the statement that applies to you and provide all requested information.

Name of Student _____

❑ **I am a US citizen or a permanent resident. I have health insurance and have enclosed a copy of the front and back of my card.**

Policy Holder's Name_____ Date of Birth: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Group Number: _____ ID Number: _____

Phone Number: _____

❑ **If am a US citizen or a permanent resident and I am not currently covered by health insurance. I would like to receive information about plans that may be available.**

❑ **I am an international student and would like to receive information about plans that may be available.**

PLEASE SUBMIT INFORMATION TO:

Bryn Athyn College Health Services
PO Box 915
2945 College Drive
Bryn Athyn, PA 19009
Fax: 267-502-6024