rustinternationalassociates
1605 n. ankeny blvd., suite 120
ankeny, ia 50023
877-964-7900 or fax: 515-964-7911

REQUEST FOR STUDENT HEALTH INSURANCE PROPOSAL

The following information is provided for use in preparing a proposal for our consideration.

DUE DATE _____

Name of College or University _____

Address _____

City _____ **State** _____ **Zip** _____

Contact Person _____

Phone No. _____ **Fax No.** _____

Number of Enrolled International Students _____ **Anticipated Insurance Enrollment** _____

Method of Participation

___ **Mandatory. All enrolled international students are to be insured.**

___ **All enrolled international students except those with a properly completed waiver are to be insured.**

___ **Voluntary. Only those who complete an application for coverage are to be insured.**

Availability of Student Health Service at your institution.

___ **None** ___ **First aid & non-prescription drug dispensary.**

___ **Walk-in clinic dispensing prescription drugs.**

___ **Clinic with facilities for overnight stay.**

Does your school currently have a Student Health plan? ___ Yes ___ No

If yes, please attach a copy of the current brochure.

Do you want to duplicate the current plan? _____

Are there special features you wish to include (or exclude)? _____

_____

Signature of Authorized Official

Title _____ Date _____

PAST INSURANCE EXPERIENCE

To have a clear understanding of the College/University current insurance plan we need the following information on plan performance.

Year	Earned Premium	Incurred Losses	Number of Losses

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THANK YOU FOR YOUR INTEREST IN OUR STUDENT HEALTH INSURANCE PLANS

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