

**MANDATED HEALTH CARE AGREEMENT
INTERNATIONAL STUDENTS ONLY**

Dear Parent/Guardian:

Out of concern for the health and welfare of all our students, Darrow School requires that every student be covered by a comprehensive injury and sickness plan, one that meets the high cost of medical services and is accepted by local providers and practitioners.

- **Please note that our health center will not accept medical insurance policies issued in a foreign country or from a company outside the United States.**

To help you meet your financial responsibilities we offer the following comprehensive plan:

PREMIER HEALTH PLAN

Provides primary, first dollar benefits for those of you who do not have any insurance or whose coverage is not accepted outside your geographical area. This plan will cover students anywhere in the world, except your home country, for a full 12 month period 8/15/2016-8/14/2017 for a premium of \$1,740 or a 10 month period 8/15/2016-6/14/2017 for a premium of \$1,575. This plan was designed especially for private secondary schools.

**INTERNATIONAL STUDENTS WHO DO NOT HAVE COVERAGE WITH A USA BASED COMPANY
(AS A DEPENDENT ON THEIR PARENT'S PLAN) MUST ENROLL.**

You must select one of the two options provided below. Please note that this document is an addendum to your Enrollment Agreement and both your Agreement and this Addendum must be returned together to the school.

Please check the appropriate boxes below, include student's name, sign your name, date and return promptly to (*fill in appropriate location and/or contact*). Thank you.

2016-2017 STUDENT INJURY & SICKNESS PLANS

1. Enroll _____ in plan for:
STUDENT NAME
 A full 12 months (\$1,740 for 8/15/2016-8/14/2017)

2. Enroll _____ in plan for:
STUDENT NAME
 A full 10 months (\$1,575 for 8/15/2016-6/14/2017)

3. Do not enroll _____ in the plan. In making
STUDENT NAME

this selection, I accept full responsibility for all medical costs incurred by my child. My present in-force plan is as follows: (Please include a copy of the front and back of your insurance card)

INSURANCE COMPANY NAME

POLICY NUMBER & PHONE NUMBER

INSURANCE COMPANY ADDRESS

CITY, STATE AND ZIP CODE

SIGNATURE OF PARENT OR GUARDIAN

DATE