**Rust & Associates**
**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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