University of the Incarnate Word

4301 Broadway, San Antonio, TX 78209

(210) 829-6000

I _____, have elected to purchase the international health insurance plan required by the University of the Incarnate Word (UIW) during the UIW sponsored international program.

I understand the cost of this insurance is _____ ($47.50/month) and that it will be charged to my student account. I understand the cost of the insurance is nonrefundable. The cost of this insurance will be determined by the amount of months I am traveling abroad. I agree to pay this amount to the University of the Incarnate Word.

Signature: _____

Printed Name: _____

ID Number:_____

Date: _____