

Professional Practice Health Insurance Certification

One of the requirements for participation in Professional Practice (Cooperative Education/Internships) is that each student have adequate health/accident insurance coverage in force during the entire period of participation.* Coverage must be either privately procured or obtained through the University's Group Health Insurance plan.

Your signature below attests to your acknowledgement and acceptance of the following statements:

I understand that any medical or dental expenses incurred while participating in the Professional Practice program are my sole responsibility not that of Illinois State University, the Board of Trustees or their agents or employees. I understand that it is my responsibility to pay any expenses, which may not be covered by insurance payments made on my behalf.

I understand that if I register for nine (9) or more credit hours by the 15th day Fall/Spring. I will be automatically assessed for and be included in the student group insurance plan. If I register for six (6) or more hours by the 8th day of the summer session. I will automatically be assessed for and be included in the student group insurance plan. If I am registered for fewer hours, I am eligible to purchase student group insurance

If you will not have ISU's insurance, you should review your other policy's coverage to determine its adequacy. In this case, a copy of an insurance card or other verification of insurance coverage MUST be attached to this form. The department will retain the copy or verification along with this form, which must be submitted to your department Professional Practice Coordinator, at the time you submit the Override Form.

CHECK THE ONE OR ONES THAT APPLY:

___ I will be covered for the entire period of my participation by ISU student insurance because I have

(check one):

___ (1) enrolled for sufficient credit hours to be assessed the student health insurance fee,

___ (2) paid the fee directly to the Student Insurance Office.

___ I am not covered by ISU student insurance and have attached verification of my privately secured policy applicable to my entire period of Professional Practice participation.

___ I have both ISU's student group plan and another policy for maximum protection

Signature: _____ Date: _____

**FAILURE TO COMPLETE AND RETURN THIS FORM
WILL PRECLUDE PARTICIPATION IN THE PROFESSIONAL PRACTICE
PROGRAM**