The University of Michigan-Dearborn
Counseling & Support Services
2157 University Center
4901 Evergreen Rd
Dearborn, MI 48128-1491
Tel: 313-593-5430 Fax: 313-593-3263
Email: counseling@umd.umich.edu

Medical Evacuation/Repatriation Enrollment Form

On Call International
Supplemental Repatriation and Medical Evacuation

Name: ____ ____
Last First

Address: ____

Telephone: ___________________________ **Email:** ____

UMID:___________________________ **Birth date:** __________________(mm/dd/yyyy) **Gender:** ☐ **M** ☐ **F**

Coverage begin date _________________ **Coverage End Date** *** ___________________

**** For F-1 students, coverage end date must be the end date for Form 1-20 or of the Optional Practical Training Employment Authorization, whichever is later For J-1 students or scholars, the end date must be the end date of Form /DS-2019.*

Dependents to be covered on this plan:

Name	Relationship	Date of Birth	Gender
______________________________________	____________	____________	_______
Name	**Relationship**	**Date of Birth**	**Gender**
______________________________________	____________	____________	_______
Name	**Relationship**	**Date of Birth**	**Gender**
_____________________________________	____________	____________	_______
Name	**Relationship**	**Date of Birth**	**Gender**
_____________________________________	____________	____________	_______

Please note that this coverage is billed by policy year (September 1 through August 31) and cannot be pro-rated. Coverage will be effective on the date that this form is received and authorized by the University of Michigan-Dearborn's Counseling & Support Services office, or on the coverage start date, whichever is later.

- I certify that I meet the eligibility requirements for this coverage as described in the University of Michigan International Plan brochure http://internationalcenter.www.umich.edu/healthins/IntlIns0607.pdf.
- I authorize the University's Cashiers/Student Accounts Office to bill me for this coverage and I accept responsibility for payment of these charges. I understand that the University of Michigan will continue to bill me through the coverage end date above unless I have submitted and the Counseling & Support Services' office has approved a Change Form altering the coverage end date.
- By signing this enrollment form, I authorize my health care provider(s) to release to Aetna Life Insurance Company, *Chickering Claims Administrators (CCA)* and *On Call International.* any information regarding services or claims made under this plan.

Your Signature: ____ Date: ______________________

For Office Use Only: Counseling & Support Services authorization:

Signature: ________________________________ *Date:* ______________________