

STUDENT HEALTH INSURANCE PLAN

Dear Parents:

Out of concern for the health and welfare of our students and their parents, Trinity-Pawling School has established a policy, which requires every enrolled student to be covered by a sickness and accident insurance plan. The cost of medical services in the United States is high and in order to be sure that the student's medical needs are met, while he is here, and that the family's financial well being is protected, good medical insurance coverage is necessary. In the past, some students have arrived at the school to begin the academic year either without any medical insurance or without adequate coverage.

To assist students and parents who may need to purchase an insurance plan to fulfill this requirement, The School now offers two policies that will cover a student. The first covers a full 12-month period (August 15, 2011 through August 15, 2012), anywhere in the world, for an annual premium of \$1,640. The second covers a 10-month period (August 15, 2011 through June 15, 2012), anywhere in the world, for an annual premium of \$1,490. These plans were designed especially for private secondary schools and meet the mandated requirements of New York State law. The basic provisions and exclusions of the plans are outlined in the summary attached. Certificates with further details will be issued to each participant along with a personal identification card.

Any international student who does not have coverage with a United States based insurance company, either as an individual or as a dependent on his parent's plan, must be enrolled.

Parents must complete the Waiver Form below and return it to the school. Only if there is existing coverage with a United States based insurance company, with complete information about the plan entered on the waiver form, will the charge for \$1,640 be removed from the bill.

IF WE DO NOT HEAR FROM YOU IMMEDIATELY, THE STUDENT WILL BE AUTOMATICALLY ENROLLED IN THIS STUDENT HEALTH INSURANCE PLAN FOR 12-MONTHS.

**STUDENT HEALTH INSURANCE
WAIVER OF BENEFITS**

I do not wish to carry Student Health Insurance on _____,
and I waive all rights to benefit under the policy. (Student Name)

My in-force Health Insurance Plan (REQUIRED) is:

_____	_____
Plan Name	Certificate Number
_____	_____
Plan Address	State & Zip Code
_____	_____
Signature	Date

**THIS STUB MUST BE COMPLETED AND RETURNED TO THE
BUSINESS OFFICE IMMEDIATELY, otherwise the student
will be automatically covered for Student Health Insurance.**