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STUDY ABROAD EXTENSION FORM

Full Name: _____

US Institution: _____

Program Name: _____

Visiting Country: _____

Original Dates of Coverage: _____

Extended Dates of Coverage: _____ *MAXIMUM: 8 Weeks*

Extended Day/s: _____ **Day/s** - Please include your departure and/or arriving date

Total Premium: \$ _____ .00 (\$1.00 per day for the participant)

Method of Payment:

Check: Please mail to the above address along with this form

Credit Card (VISA – MC – AMEX): Please mail, fax or Email.

Number: _____

Exp. Date: ____/____

Mailing Address: _____

Phone Number: _____

Email Address: _____

Signature

Date: _____