TUFTS UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF INTERNATIONAL AFFAIRS

OFFICE USE: APPLICATION NUMBER

INTERNATIONAL APPLICANT HEALTH INSURANCE COVERAGE STATEMENT

Please fill out form in Adobe Reader (free download available here). When complete, save with a new document name (e.g., Abdel Haddad Application) before sending. Do not submit with hand-written responses

- Name: (First)
  (Middle)
  (Last)
- Permanent (Home Country) Address:
- Address in U.S. (If Known):
- Health Insurance Coverage:
  - Name of Insurance Company
  - Policy/Member Number
  - Policy Expiration Date (mm/dd/yyyy)
  - Subscriber's Name
  - Relationship of Subscriber to Applicant

I understand that I am responsible for my medical expenses. By entering my name and the date below, I attest that I am covered by the health insurance policy listed above, and that this coverage continues through the entire duration of my Tufts-affiliated program in the United States. I attest that this plan provides preventive and primary care, emergency services, hospitalization benefits, ambulatory patient and mental health services.

Name of Applicant Attesting the Above:

Date (mm/dd/yyyy):