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BETHANY COLLEGE OF MISSIONS

MEDICAL COVERAGE REPLY FORM
Single Student

Date ___________________

Name____ **Age**_____ **Gender** _____

Parent's/Guardian's Name(s)____

Address____

____

Telephone (___)_______________________________

Select all that apply:

____ **I am covered under the following medical insurance company(ies):**

Please attach a copy of your insurance card(s).

Company ____

Name of Policy Holder _____________________________________

Policy Number ____

Policy Expiration Date _____________________________________

Company ____

Name of Policy Holder _____________________________________

Policy Number ____

Policy Expiration Date _____________________________________

____ **I will apply for the Parkway Plan upon enrollment.**

____ **I will apply for the Liasion International Plan** (International and Canadian students only)

This form must be returned to the BCOM Admissions office by
November 24 for spring enrollment or July 6 for fall enrollment
to the following address:

Admissions Office, 6820 Auto Club Rd, Suite C, Bloomington, MN 55438