



OHIO
UNIVERSITY

**STUDENT HEALTH INSURANCE APPLICATION
ATHENS CAMPUS ONLY**

Term _____

Student's Name

P_____
University ID #

Yes, enroll me in the Ohio University Student Injury and Sickness Insurance Plan effective with the ___ Fall ___ Winter ___ Spring ___ Summer term. Your university account will be billed for the cost of the insurance premium.

Signature

Date

Mail this form to:

**Ohio University
Office of the Cashier
Chubb Hall
Athens, Ohio 45701-2979**

*For information about the student insurance plan go to: www.studentresources.com/college/viewbrochures.aspx
Choose Ohio University from the drop down menu.*