

## HEALTH INSURANCE ATTACHMENT

Health Insurance Carrier

\_\_\_\_\_  
Carrier's Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Date

Please note: You should check with your insurance carrier concerning your coverage while you are interning.

**I currently do not have health insurance.**

\_\_\_\_\_  
**Student's Name**

\_\_\_\_\_  
**Date**

**(This form must be completed and returned to the Internship Coordinator Office)**

**GEORGETOWN COLLEGE INTERNSHIP PROGRAM  
400 East College Street, Georgetown, KY 40324-1696 502-863-7094 Fax 502-868-7750**