July 2020

REQUEST FOR AMERICAN INCOME MEDICAL/AD&D COVERAGE

Form RM05

Date of Request: _____ **Approx. # of People Attending/Traveling:** _____

Prepared by:

Name _____

Phone # _____

E-mail Address _____

Dept Name _____

Program/Activity Name _____

Campus Location ◯ **West Lafayette** ◯ **Fort Wayne** ◯ **Northwest - Hammond** ◯ **Northwest - Westville**

Group Leader, Camp Director, or Professor:

Name _____

Phone # _____

E-mail Address _____

Billing Information:

Order Number _____

WBSE Number _____

Travel/Camp Location Info:

City _____

State _____

Start Date _____

Campus Location ◯ **PFW** ◯ **PNW** ◯ **WL**

Company/Park/Business Name _____

End Date _____

*** PLEASE PROVIDE A ROSTER IN EXCEL WITH THE BELOW INFORMATION; THE FORM & ROSTER CAN BOTH BE E-MAILED TO LEHIGH@PURDUE.EDU. ***

For participants under 18 yrs old

First Name	Last Name	E-mail Address	Child's Age	Parent or Guardian Name	Parent's E-mail	Parent's Phone #