

**REQUEST FOR AMERICAN INCOME MEDICAL/AD&D COVERAGE**

**Date of Request:** \_\_\_\_\_

**Approx. # of People Attending/Traveling:** \_\_\_\_\_

**Prepared by:**

**Group Leader, Camp Director, or Professor:**

Name \_\_\_\_\_

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

E-mail Address \_\_\_\_\_

E-mail Address \_\_\_\_\_

Dept Name \_\_\_\_\_

Program/Activity Name \_\_\_\_\_

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

**Billing Information:**

Order Number \_\_\_\_\_

WBSE Number \_\_\_\_\_

**Travel/Camp Location Info:**

City \_\_\_\_\_

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

State \_\_\_\_\_

Company/Park/Business Name \_\_\_\_\_

Start Date \_\_\_\_\_

End Date \_\_\_\_\_

**\* PLEASE PROVIDE A ROSTER IN EXCEL WITH THE BELOW INFORMATION; THE FORM & ROSTER CAN BOTH BE E-MAILED TO [LEHIGH@PURDUE.EDU](mailto: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 #
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