CLAREMONT MCKENNA COLLEGE

APPLICATION PACKET
International Programs
iNext Supplemental Travel and Health Coverage

CMC requires every student traveling internationally through CMC to be enrolled in iNext International Supplemental Travel and Health Coverage. If you already have a valid iNext card, please submit a copy of the confirmation of insurance from your online profile, including the effective dates of your policy. Your current policy must be the same coverage or greater than what is required by CMC for the length and destination of your current trip.

After we complete your sign-up data, **iNext will email you.** Using the emailed instructions, you will log-in, input information and upload an ID-size photo of yourself. **iNext will then mail your card within 10 days.** The card can only be mailed to a U.S. address. You are covered by iNext whether or not you receive the card.

Personal Information

Name: _____
(last name) (first name)

Email address: _____ CMC ID #: _____

Cell Phone: ( ) _____ Date of Birth: _____

Destination(s): _____

School Name: Claremont McKenna College, Study Abroad

Date of Departure from U.S.:_____ (or date you would like coverage to begin if you will be traveling prior to your program abroad)

____ **iNext Basic Plan:** $32.00
(for trips less than 4 weeks)

____ **iNext Platinum Plan:** $90.00
(for trips 4 weeks or longer)

Method of payment:

____ Check made payable to CMC;

____ The sponsoring faculty or department will pay. (Please attach approval and account number from the sponsoring department.)

Check One:
In case of emergency ☐ I authorize ☐ I do not authorize a representative of CMC to receive, consistent with applicable privacy laws, updates on the status of any emergency or other medical assistance claims from iNext and Seven Corners/Nationwide.

Only health information from _____ (travel start date) to _____ (travel end date) may be shared.

ACKNOWLEDGMENT
I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I hereby certify that this information is true and I understand that any false statements on my part may result in forfeiture of the benefits associated with this card.

Signature of Cardholder: _____ **Date**: _____