Claremont McKenna College
Short-term International Travel Sponsored by CMC
iNext Supplemental Travel and Health Coverage

CMC requires every student sponsored by CMC and traveling internationally to be covered by an iNext International Supplemental Travel and Health Coverage Policy. Effective December 2019, iNext coverage is on a *per trip* basis. As such, each trip will require a new form, payment, and ensuing policy number.

Student:
1. Complete the below information.
2. Submit this form to the sponsoring department per their instructions.

Sponsoring department:
1. Collect form(s) from the student(s).
2. Review form(s) and verify the iNext Policy (Basic or Platinum).
3. Verify funds or account number for payment.
4. Deliver original form(s) to the Center for Global Education at least ten (10) business days prior to the departure date.

After CGE uploads the information from this form, **iNext will email the insured.** Using the emailed instructions, login, provide requested information, and upload an ID-size photo. **iNext will then mail your card to you within 10 days.** The card will only be mailed to a U.S. address, however, coverage commences on the below date even if the card is not in your possession.

School Name: Claremont McKenna College **CMC ID Number:** _____

Last Name: _____ **First Name:** _____

Email address:_____ **Cell Phone:** _____

Date of Birth: _____ **Destination(s):**_____

Date of Departure from U.S. or date you would like coverage to begin for pre-program travel**:** _____

____ **iNext Basic Plan $32.72** for trips less than four (4) weeks ____**iNext Platinum Plan $92.60** for trips four (4 weeks or longer)

Method of payment: _____ Check made payable to CMC _____The sponsoring faculty or department will pay.
(Attach approval and account information from the department.)

Check One:

In case of emergency ☐ I authorize or ☐ 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/Crum and Forster SPC and Generali Global Assistance.

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**: _____