Certification of Insurance for GSE Team Members

Completion of this form is MANDATORY for travel ticket release. Please print or type.

I hereby certify that I have investigated actual costs of hospitalization/medical care in my host country and have obtained the following minimum required insurance coverage, valid in the country(ies) in which I will travel and study during my participation in the Group Study Exchange program, from the date of my departure through the date of my return home.

US$50,000 or equivalent for basic major medical expenses, including accident and illness expense, hospitalization, and related benefits

NAME OF COMPANY ISSUING MEDICAL CARE, HOSPITALIZATION, AND EMERGENCY MEDICAL EVACUATION COVERAGE AND POLICY NUMBER

US$10,000 or equivalent for emergency medical evacuation

NAME OF COMPANY ISSUING MEDICAL CARE, HOSPITALIZATION, AND EMERGENCY MEDICAL EVACUATION COVERAGE AND POLICY NUMBER

US$10,000 or equivalent for accidental death and dismemberment

NAME OF COMPANY ISSUING ACCIDENTAL DEATH AND DISMEMBERMENT AND REPATRIATION OF REMAINS COVERAGE AND POLICY NUMBER

US$7,500 or equivalent for repatriation of remains

NAME OF COMPANY ISSUING ACCIDENTAL DEATH AND DISMEMBERMENT AND REPATRIATION OF REMAINS COVERAGE AND POLICY NUMBER

I further certify that if my insurance coverage was already in effect and/or was obtained locally, I have examined this coverage and confirm that my policy provides the required minimum coverage for medical care, hospitalization, emergency medical evacuation, accidental death and dismemberment, and repatriation of remains. It is valid in the country(ies) in which I will travel and study during my participation in the Group Study Exchange program.

Please indicate below the inclusive period this insurance will be in effect. The insurance coverage must be from the date of departure through the date of your return home.

FROM: _____/_____/_____ TO: _____/_____/_____
DAY MONTH YEAR DAY MONTH YEAR

NAME OF GSE PARTICIPANT (PLEASE PRINT) DISTRICT

SIGNATURE OF GSE PARTICIPANT DATE

Medical Certificate for GSE Team Members

Date: _____

I have this day examined _____
NAME OF GSE PARTICIPANT (PLEASE PRINT)

and found him/her to be in good health and enjoying full working capacity. He/She is physically and mentally able to carry on an intensive program of study and travel away from home.

NAME OF EXAMINING PHYSICIAN (PLEASE PRINT)

ADDRESS CITY, STATE OR PROVINCE COUNTRY

SIGNATURE OF EXAMINING PHYSICIAN

DUE TO GSE CHAIR TWO MONTHS BEFORE DEPARTURE
Detach and return this form to the district GSE chair.
GSE chair should send copies of this form and Team Member Applications for the entire team to GSE staff.
Please send predeparture documents for the entire team together.