FORM VII
STATEMENT OF INSURANCE COVERAGE
Western Illinois University
School of Law Enforcement and Justice Administration

I,__________________________________, certify that I have paid for the Student Health Insurance
(Student's Name)
Program that is provided to Western Illinois University Students (or have voluntarily waived University Insurance by providing, verifying, and maintaining an equivalent policy through a private insurance representative) and that I will not cancel or change this insurance coverage during the period of my internship. I further represent that I am above the age of 21 years*, with full understanding of all risk involved and agree that this "Statement of Insurance Coverage" shall be binding upon my heirs, executors, administrators, and assignors.

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Student Signature

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Witness Signature

** For persons under the age of 21, parental signature required*

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Parental Signature