Indiana University of Pennsylvania

Office of International Education
920 Grant Street
B25 Delaney Hall
Indiana, Pennsylvania 15705

P 724-357-2295
F 724-357-2514
intl-education@iup.edu

Dear New IUP International Student:

Congratulations on your admission to Indiana University of Pennsylvania! We look forward to meeting you soon. Complete our pre-arrival orientation (https://register.homebase.english3.com/?code=828&institution=183) to learn more about F1 status, IUP, and our community.

Plan to arrive at IUP on or before the start date in your immigration document (Fall 2025 - August 18 | Spring 2026 - January 12) for International Student and Scholar Orientation Week. F-1 and J-1 visa holders can enter the U.S. up to 30 days prior to this date. Here is a checklist for you as you prepare for your studies at IUP.

International Student Checklist:

1. Apply for a U.S. visa (or transfer document to IUP, if already in the U.S.)
2. Reserve Housing and Dining
3. Activate your IUP Email
4. Graduate Students should register for classes prior to entering the U.S. See your admission letter with your Graduate Coordinator's contact information.
5. Purchase Health Insurance
6. Plan your airport transportation – IUP Airport Transportation is available on arrival day- August 18 or January 12 only ($60)
7. Attend mandatory International Student Orientation – Fall August 19-22 | Spring January 13-16.

More detailed information about the list above can be found on our website: www.iup.edu/international/students-scholars/students/new/arriving-at-iup. Check out the IUP international student portal at https://iup-isss.terradotta.com.

Additional resources can be found in our *International Student Handbook* available at www.iup.edu/international/students-scholars/students/new/your-first-week.

Please email or message us with any questions. We look forward to meeting you!

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intl-education@iup.edu
www.iup.edu/international

Follow us on social media
Facebook: facebook.com/IUPOIE
Instagram: IUPOIE

Homeland Security Investigations

U.S. Department of Homeland Security
500 12th Street NW, MS 5600
Washington, DC 20536-5600

U.S. Immigration and Customs Enforcement

SEVP Policy Guidance: Use of Electronic Signatures and Transmission for the Form I-20

Regulatory and Statutory Background: *8 CFR 214.3(k)*

Date: October 12, 2021

Purpose: This guidance establishes the Student and Exchange Visitor Program's (SEVP) procedures for the use of electronic signatures on the Form I-20, "Certificate of Eligibility for Nonimmigrant Student Status," and electronic transmission of the form. School officials should use the following guidance when issuing the Form I-20 to initial and continuing nonimmigrant students and their dependents.

Background: Authorizing regulations require school officials to sign the Form I-20 before issuing the form to nonimmigrant students and their dependents (*8 CFR 214.3(k)*).

The COVID-19 pandemic disrupted international mail and courier services in 2020. When designated school officials (DSOs) and students were unable to physically meet on campus due to travel restrictions and closed campuses, SEVP allowed the Form I-20 to be signed and transmitted electronically. This reduced the burden on students, DSOs, and their respective institutions and avoided pandemic-related disruptions to the enrollment and education of nonimmigrant students. Allowing electronic signatures and transmission also expedited issuance of the Form I-20 and helped to avoid expenses and complications related to mailing documents.

In response to Executive Order 14012, "Restoring Faith in Our Legal Immigration Systems and Strengthening Integration and Inclusion Efforts for New Americans," SEVP identified recommendations to increase efficiency in the immigration system and reduce unnecessary burdens. Accordingly, SEVP has formally adopted the use of electronic signatures and transmission for the Form I-20.

Attachments: None

Acronyms:

1. **DSO.** Designated school official
2. **SEVP.** Student and Exchange Visitor Program

Policy:

1. **Use and acceptance of electronic signatures.** DSOs may physically sign the Form I-20 or input their own electronic signature. SEVP accepts electronic signatures in the following forms.

   1.1. *Electronic signatures using software programs or applications.* School officials may sign all signature fields on the Form I-20 using electronic signatures produced with software programs or applications.

   1.2. *Electronically reproduced copies of a signature.* School officials may sign all signature fields on the Form I-20 using digitally reproduced copies of a signature. A digitally reproduced copy may be a scanned image of a physical signature.

2. **Electronic transmission of the Form I-20.** School officials may scan and email an electronic version of a Form I-20 that has been signed using either a physical or electronic signature, as outlined in Section 1, to nonimmigrant students and their dependents. Alternatively, school officials may use a secure platform that students can access with individual account credentials to send an electronic version of a Form I-20. This may include a school portal or other secure site that students can access.

   Upon receipt of the electronically transmitted Form I-20, students should print a copy to present at any required visa interview and upon arrival at a U.S. port of entry.

References:

8 CFR 214.3(k)

Limits of use—no private right of action:

This SEVP Policy Guidance applies to and is binding on all SEVP employees unless specifically exempt. Its intention is solely for the guidance of SEVP personnel in the performance of their official duties. Nothing in this guidance limits SEVP's authority or discretion to interpret, administer or enforce any statute, regulation, policy or guidance related to SEVP certification. This guidance may be modified, superseded or withdrawn at any time. It is not intended to, does not, and may not be relied upon to create or confer any right or benefit, substantive or procedural, enforceable at law or in equity by any person, individual or other party, public or private, in any administrative, civil or criminal matter.

James D. Hicks
Division Chief, External Operations
Student and Exchange Visitor Program

Indiana University of Pennsylvania

Return To: Health Services, Center for Health and Well Being Suites on East Maple, Suite G-65, 901 Maple Street Indiana, PA 15705
Phone: 724-357-2550 / Fax: 724-357-6212 / Health-Inquiry@iup.edu

REQUIRED IMMUNIZATIONS

There is currently no physical required for admission to IUP. A health history form is required in addition to the recommended immunizations listed below. **Mail or fax this form to the address at the top of the form prior to or upon arrival to campus**

Name: _____ **Banner ID: @**_____
Last First

Date of Birth (MM-DD-YY):_____ **Gender:** ☐ Male ☐ Female

NON-IUP e-mail address:_____ **IUP e-mail**_____

Enrollment Period: ☐ FALL ☐ SPRING _____ YEAR Phone Number: _____

Immunization	Dates Administered		
Combined MMR dates (No Single shots)	Dose 1 / /	Dose 2 / /	Titers: Document attached.
Meningococcal Meningitis	Dose 1 / /	Dose 2 / /	
Meningococcal Meningitis	☐ Waiver ☐ Student Initial ___	Date / / Of waiver (REQUIRED)	
Hepatitis B dates	Dose 1 / /	Dose 2 / /	Dose 3 / /
Hepatitis B	☐ Waiver Student Initial _____	Date / / Of waiver (REQUIRED)	Titers: Document attached.
Polio (oral or trivalent)	Dose 1 / /	Dose 2 / /	Dose 3 / /
Last Tetanus (Td, DT, TdaP, etc) (SHOULD BE WITHIN 10 YEARS)	Dose 1 / /		
COVID-19 Vaccine **Type:** _____	Dose 1 / /	Dose 2 / /	Dose 3 / /

PROOF OF FREEDOM FROM TUBERCULOSIS

PROOF OF FREEDOM FROM TUBERCULAR DISEASE (Result of tests must be verified by a health care provider)

Mantoux Skin Test (PPD) Date Given_____ Date Read_____ Results_____(record in millimeters) .
If + (positive) Chest X-Ray Result: _____ (attach copy)

BCG Vaccine Date: _____
IGRA Screening: _____T-Spot / Date _____ Result _____
_____Quantiferon Gold / Date _____ Result _____

Attach a physician's summary of status of any positive TB testing in past (Chest X-ray results, treatment/preventative therapy for TB, etc.)

Indiana University of Pennsylvania
Health Service
Center for Health and Well Being - Suites on Maple East
Suite G-65, 901 Maple Street
Indiana, PA 15705
Phone: 724-357-2550 / Fax: 724-357-6212

Emergency Contact:

Name:_____

Relationship: _____

Phone: (___) _____

HEALTH HISTORY

This information is strictly for the use of the Health Service and will not be released to anyone without your knowledge and written consent unless released in response to a court subpoena/order.

DEMOGRAPHICS: Today's Date: ___/___/_____

STUDENT'S LAST NAME	FIRST NAME	(PREFERRED NAME)	MI	Date of Birth

SS#	GENDER	Marital Status	Class Status
		__S __M __D __W __ Legal Sep.	__Fr __So __Jr __Sr __Grad. __A.L.I. __Transfer

HOME ADDRESS

CITY	STATE	ZIP	(AREA CODE) PHONE

INSURANCE INFORMATION ***If no information given, or student does not have health insurance, charges may be sent to student***

Insurance Co. Name: _____

Ins. Co. Address:_____

Ins. Co. Phone #:_____

ID#:_____ **Group #:**_____

If HMO, list name of Primary Care Physician (PCP):
_____

PCP Phone#:_____ **PCP Fax #:** _____

INSURANCE CARRIER INFORMATION:

Name of Person Carrying Insurance:_____

Address: _____

_____

Phone #: (____) _____

Social Sec. #: _____

Employer: _____

Address: _____

Phone #: (____) _____

PERSONAL HEALTH HISTORY

Are you allergic to any medication(s)? YES_____ NO_____

If yes, list medication(s) and reaction(s): _____

Do you avoid taking any medications due to side effects ? YES _____ NO_____

If yes, list medication(s) and side effect(s): _____

Please list any Food Allergies: _____

Do you take allergy medications? YES_____ NO_____ If yes, specify allergens and frequency that medications are taken: _____

_____

Are you currently taking daily medications? If yes, please list drugs (Include prescription drugs, vitamins, herbal supplements,weight loss products, birth control pills, over the counter medications taken regularly, etc) and dosages:_____

_____

SOCIAL HISTORY: DO YOU …

Smoke pipe, cigar, cigarettes? Y N Chew smokeless tobacco? Y N Use street drugs? Y N If yes, list name(s) of drug(s) : _____

Drink alcohol? Y N If yes, frequency: Average number of drinks at one time: _____ **Number of drinks per week:** _____

CONTINUED ON BACK

Mail or fax this form to the address at the top of the form prior to, or upon arrival to campus.

Indiana University of Pennsylvania
Health Service

Student Name:_____

If NONE of the items below apply please check here ☐ N/A.

Infectious	SELF	FAMILY	RELATIONSHIP
Tuberculosis			
Hepatitis A, B or C (Circle)			
HIV Status			
Mononucleosis			
Chicken Pox			
Intestinal	SELF	FAMILY	RELATIONSHIP
Gallbladder Disease			
Gastroesophageal Reflux Disease (GERD)			
Liver Disease			
Colonic Polyps			
Inflammatory Bowel Disease			
Other:_____			
Reproductive	SELF	FAMILY	RELATIONSHIP
FEMALE			
Ovarian Cysts			
Fibrocystic Changes/ Breast Disorders			
Past Pregnancy			
Pelvic Infections			
Other:_____			
MALE			
Hernia			
Testicle Problems			
Other:_____			

Respiratory	SELF	FAMILY	RELATIONSHIP
Chronic Obstructive Pulmonary Disease (COPD)			
Cystic Fibrosis			
Asthma			
Pneumonia			
Other:_____			
Endocrine	SELF	FAMILY	RELATIONSHIP
Thyroid Disease			
Diabetes			
Hypoglycemia			
Adrenal			
Other: _____			
Bone or Joint Disease	SELF	FAMILY	RELATIONSHIP
Scoliosis			
Arthritis			
Other: Describe:_____ _____			
Cardiovascular	SELF	FAMILY	RELATIONSHIP
Heart Attack			
High Blood Pressure			
Stroke			
Heart Murmur			
Other: _____			

Emotional	**SELF**	**FAMILY**	RELATIONSHIP
Attention Deficit Disorder			
Bipolar Disease			
Depression			
Anxiety			
Panic Attacks			
Suicide Attempts			
Alcohol / Substance Abuse			
Learning Disability(Describe) _____			
Eating Disorder (Describe):_____ _____			
Other:_____ _____			
Neurologic	SELF	FAMILY	RELATIONSHIP
Seizure Disorder			
Headaches (Type of) _____			
Seizure Disorder			
Multiple Sclerosis			
Other:_____			
Cancer	SELF	FAMILY	RELATIONSHIP
Specify Type :			

1. Do you have an illness or condition not listed in the Past Medical History, for which you are now being treated? If yes, please specify below:

2. Have you ever had any significant injuries, e.g. head injury, fractures, severe strains or sprains, or any other trauma? Please specify type of injury and date of occurrence.

3. Do you have a chronic or long-term on-going condition? (If yes, please have your physician write a medical summary and attach it to this form.)

4. List date(s) and reason(s) for any other hospitalizations.

5. Do you have any physical disabilities or need any assisted devices? (e.g. glasses, contact lenses, hearing problems, mobility devices, etc.)

AUTHORIZATION FOR TREATMENT

(THIS IS TO BE COMPLETED AND SIGNED BY THE STUDENT. STUDENTS WHO ARE UNDER EIGHTEEN (18) YEARS OLD MUST ALSO HAVE THE SIGNATURE OF PARENT/GUARDIAN.)

In case of serious illness or accident, I give Indiana University of Pennsylvania or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a non-serious condition requiring minor care, I approve of care by the University's Registered Nurse.

_____

STUDENT SIGNATURE **PARENT/GUARDIAN SIGNATURE** **DATE**

Indiana University of Pennsylvania
Health Service

Student Name:_____

If NONE of the items below apply please check here ☐ N/A.

Infectious	SELF	FAMILY	RELATIONSHIP
Tuberculosis			
Hepatitis A, B or C (Circle)			
HIV Status			
Mononucleosis			
Chicken Pox			
Intestinal	SELF	FAMILY	RELATIONSHIP
Gallbladder Disease			
Gastroesophageal Reflux Disease (GERD)			
Liver Disease			
Colonic Polyps			
Inflammatory Bowel Disease			
Other:_____			
Reproductive	SELF	FAMILY	RELATIONSHIP
FEMALE			
Ovarian Cysts			
Fibrocystic Changes/ Breast Disorders			
Past Pregnancy			
Pelvic Infections			
Other:_____			
MALE			
Hernia			
Testicle Problems			
Other:_____			

Respiratory	SELF	FAMILY	RELATIONSHIP
Chronic Obstructive Pulmonary Disease (COPD)			
Cystic Fibrosis			
Asthma			
Pneumonia			
Other:_____			
Endocrine	SELF	FAMILY	RELATIONSHIP
Thyroid Disease			
Diabetes			
Hypoglycemia			
Adrenal			
Other: _____			
Bone or Joint Disease	SELF	FAMILY	RELATIONSHIP
Scoliosis			
Arthritis			
Other: Describe:_____			
Cardiovascular	SELF	FAMILY	RELATIONSHIP
Heart Attack			
High Blood Pressure			
Stroke			
Heart Murmur			
Other: _____			

Emotional	**SELF**	**FAMILY**	RELATIONSHIP
Attention Deficit Disorder			
Bipolar Disease			
Depression			
Anxiety			
Panic Attacks			
Suicide Attempts			
Alcohol / Substance Abuse			
Learning Disability(Describe) _____			
Eating Disorder (Describe):_____ _____			
Other:_____ _____			
Neurologic	SELF	FAMILY	RELATIONSHIP
Seizure Disorder			
Headaches (Type of) _____			
Seizure Disorder			
Multiple Sclerosis			
Other:_____			
Cancer	SELF	FAMILY	RELATIONSHIP
Specify Type :			

1. Do you have an illness or condition not listed in the Past Medical History, for which you are now being treated? If yes, please specify below:

2. Have you ever had any significant injuries, e.g. head injury, fractures, severe strains or sprains, or any other trauma? Please specify type of injury and date of occurrence.

3. Do you have a chronic or long-term on-going condition? (If yes, please have your physician write a medical summary and attach it to this form.)

4. List date(s) and reason(s) for any other hospitalizations.

5. Do you have any physical disabilities or need any assisted devices? (e.g. glasses, contact lenses, hearing problems, mobility devices, etc.)

AUTHORIZATION FOR TREATMENT

(THIS IS TO BE COMPLETED AND SIGNED BY THE STUDENT. STUDENTS WHO ARE UNDER EIGHTEEN (18) YEARS OLD MUST ALSO HAVE THE SIGNATURE OF PARENT/GUARDIAN.)

In case of serious illness or accident, I give Indiana University of Pennsylvania or its representative(s) permission to secure medical and/or surgical care to include transportation to a physician or hospital of their choice, examination, medication and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a non-serious condition requiring minor care, I approve of care by the University's Registered Nurse.

_____

STUDENT SIGNATURE **PARENT/GUARDIAN SIGNATURE** **DATE**

DECLARATION OF DISABILITY

The Advising and Testing Center/
Disability Support Services - 216 Pratt Hall

Disability Support Services (DSS), *located within the Advising and Testing Center at IUP*, exists to **ensure equal access to education for students with all types of documented disabilities** including, but not limited to, learning, physical and psychological disabilities. DSS offers a variety of support services to assist students in meeting their educational goals. Privacy is maintained. If you have a disability, please complete the form below. We will contact you to discuss the type of services we offer.

Please be aware that IUP does not discriminate on the basis of race, gender, age, national origin, religion, sexual preference or disability in any of its educational programs or activities. We provide services commensurate with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. You should register with this office even if the Blind and Visual Services (BVS) or the Office of Vocational Rehabilitation (OVR) is servicing you, as we will work together to provide you with support services.

Whether currently applying to IUP or already admitted, **we encourage you to meet with a DSS faculty or staff advisor to review service patterns and your needs for these services.** Please call (724) 357-4067 (V/TD), or email advising-testing@iup.edu, to **schedule an appointment.**

DEMOGRAPHIC INFORMATION

Name: _____Banner ID@_____Date:_____
First Middle Initial Last

Home Address:_____
Street City State Zip

Telephone:_____Major:_____

Email Address:_____I plan to live on campus: □ Yes □ No

Local Address:_____
Street City State Zip

Local Phone:_____ Cell:_____

DISABILITY

Please indicate your *Primary Disability **(P)** and, if applicable, Secondary Disability**(S)***

_____ Health/Physical:_____
_____ Mobility:_____
_____ Hearing:_____
_____ Visual:_____
_____ Traumatic Brain Injury: _____
_____ Psychological/Emotional: _____
_____ Attention/Concentration:_____
_____ Learning: _____
_____ Other, not otherwise classified: _____

For Office Use Only:

- Status – Prosp. Current Contin. Readmit
- Student Type – FR TR GR
- Level – UG GR CE
- Entry Term _____
- Campus I P P-CULN N DE
- Application Decision INC AD AP AW PC NA

PREVIOUS ACCOMMODATIONS

As a result of the disabilities that you indicated on the previous page, what special arrangements, if any, have been made for you, or recommended, in the past? For example: note taking, recorded books, testing accommodations, etc. (Check all that apply and/or what you think might help you in the college setting. As well, list others that are not already listed below.)

__Note taking __Recorded books __Extended test time __Tests read __Quiet/separate test setting __Spell checker
__Calculator __Accessible classroom __Interpreter __Large font __Braille __Captioned materials
__Other (specify below)

_____

_____

DOCUMENTATION

Documentation of disability, and resultant functional limitations, determine the accommodations provided in the higher education setting. Please **attach** a copy of official documentation describing your disability with this form **or return this form today** and forward documentation to the address below **as soon as possible.**

▪ **Learning Disability**, please send a recent (*no more than three years old*) psycho-educational or psychological (whichever applies) report. *IEPs and NORAs do not meet the requirements for documentation*. If your documentation is more than three years old, you may submit it. We will accept it for the purpose of initiating services and will then contact you about acquiring an updated evaluation. [Please note: IUP provides federally mandated services as well as weekly advising meetings. We serve over 200 students with documented learning disabilities. We **DO NOT**, however, provide a "special" program for students with learning disabilities.]

▪ **Attention Deficit Disorder,** a diagnosis must be made by a physician or clinical psychologist. Please have the professional who diagnosed you forward the result of the tests that support this diagnosis to us.

▪ **Psychological Disability**, please send a recent psychological evaluation that states a diagnosis. Ideally, this will also include any effects on learning and any recommended accommodation.

▪ **Physical Disability**, please send medical documentation stating your disability and any limitations you may have as a result.

▪ **Hearing Loss**, please send a copy of your most recent (within the last two years) audiogram and include any limitations or necessary accommodations.

▪ **Visual Loss**, please send a copy of your most recent eye examination results. (Students who use corrective lenses must have correct vision of not less than 20/200 and include any limitations or necessary accommodations.)

▪ **Other disabilities not listed above, please have your physician or other appropriate professional send us a short letter of verification**. The letter should specify the diagnosis or type of disability, date of onset, prognosis (if applicable), and necessary accommodations.

Please return this form and documentation to:

Advising and Testing Center/Disability Support Services
Indiana University of Pennsylvania
201 Pratt Drive, Room 216
Indiana, Pennsylvania 15705
(724) 357 – 4067 (Voice/TD)
Website: http://www.iup.edu/advisingtesting
E-mail: Advising-Testing@iup.edu

Office of International Education
Delaney Hall B-25, 920 Grant Street
Indiana, PA 15705-1070
(724) 357-2295
www.iup.edu/international

IUP POLICY

Health Insurance for International Students (F and J visa)

Indiana University of Pennsylvania requires all J and F visa holders to have the Medical Evacuation and Repatriation Insurance coverage sponsored by the university. IUP will provide students who are F and J visa holders with medical evacuation and repatriation insurance, billing each student for the insurance premium at the beginning of each academic semester. No waivers are permitted.

As defined by federal regulations, students who possess J visas also must carry a minimum level of health insurance coverage for themselves and any spouse and any dependent child/children. Students may select any health insurance policy that is in compliance with the following federal requirements. Each semester of enrollment, students on a J visa must provide proof of insurance with at least $100,000 major medical coverage, per accident or illness. The deductible may not exceed $500 per accident or illness. Insurance plans must be purchased from a company that is licensed to sell insurance in the United States.

Students on a J visa must maintain valid medical insurance for the entire period of enrollment at IUP. If, at any time, the university becomes aware that the student is not covered by an insurance plan that is in compliance with the federal regulations, the student will be contacted by the Office of International Education and his or her immigration status will be in jeopardy.

Students who have commercial health insurance may also be required to pay the university health and wellness fee and any related health charges when seeking care on campus.

Choosing Your Health Insurance Plan

- ☑ Know what services are available at Student Health Center
- ☑ Do not base your decision solely on the cost of the insurance policy
- ☑ A deductible of $250 or less is best
- ☑ If you have dependents, purchase an insurance policy for them immediately
- ☑ Be sure that the policy meets U.S. minimum coverage requirements for J visas

United States Federal Guidelines: Insurance Requirements for J-Visa Visitors

a) **Minimum Coverage** – Insurance shall cover: (1) medical benefits of at least $100,000 per person per accident or illness; (2) repatriation of remains in the amount of $25,000; and (3) expenses associated with medical evacuation in the amount of $50,000.

b) **Additional Terms** – A policy secured to fulfill the insurance requirements shall not have a deductible that exceeds $500 per accident or illness, and must meet other standards specified in the regulations.

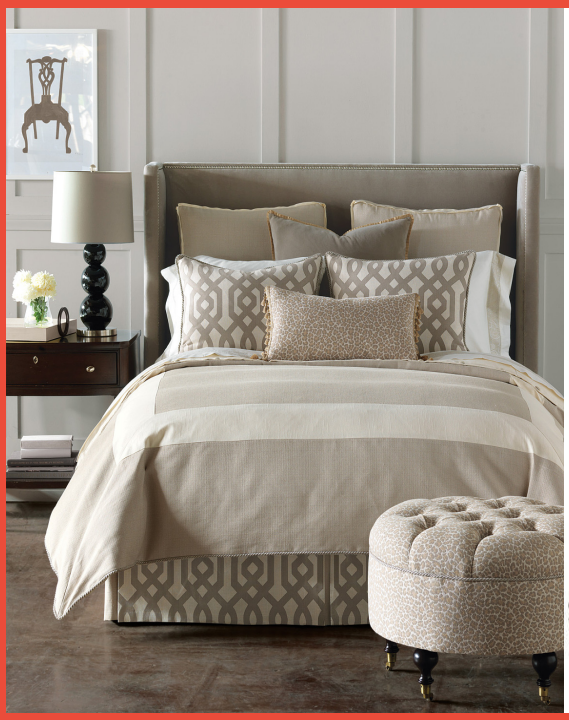
c) **Maintenance of Insurance** – Willful failure on your part to maintain the required insurance will result in the termination of your program.

These health plans are examples of the many plans available to international students. Indiana University of Pennsylvania does not support any one policy. Please review each policy. Purchase the policy that supports your needs.

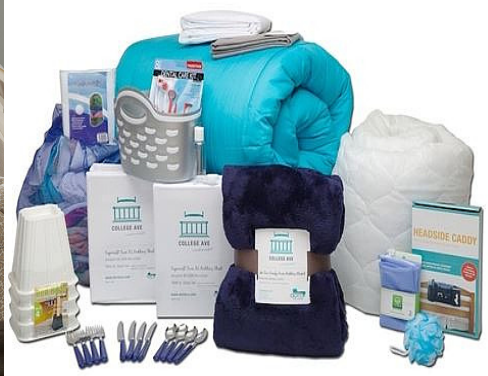
Insurance	Prenatal/Pregnancy	Dental	Eye Coverage	Prescription	Emergency Care
Cultural Insurance Services International (CISI) https://www.culturalinsurance.com/students/coming-to-u.s.asp					-Emergency medical $100,000
The Harbour Group of Ohio, LLC https://www.hginsurance.com/	Covered if Conception Occurs after coverage is in force Routine Also $4,000 Newborn Hospital Nursery Care	$2,500 (Injury Only)		$20 Generic $50 All Other $15 Oral Contraceptives	$150 Emergency Room Hospital Room and board $150
International Student Organization (ISO) www.isoa.org	Covered $7,5 00 max for normal delivery $12,000 for C section delivery				Emergency room co-pay (waived if admitted) $350 Hospitalization co-pay $500
Global Student USA - HTH Worldwide Insurance Services www.hthstudents.com	Preventative Care for Babies/Children: Office Visits/examination Immunizations, Lab work & X-rays	100% of Covered Expenses up to $500 per Calendar Year maximum (Emergency only)		Insurer waives deductible 100% of actual charge up to an annual maximum of $5,000. Maximum 90 - day supply	Ambulance services Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-ray and lab work
International Student Insurance https://www.internationalstudentinsurance.com/student-health-insurance/benefits.php	Covered as well as Newborn care, Therapeutic Termination of Pregnancy $500	Dental treatment due to accident/$250 per tooth/$500 Maximum, Dental treatment to alleviate pain/$100 Maximum		Outpatient Prescription Medication, 50% of actual charge	Local Ambulance per injury/ illness if hospitalized as Inpatient

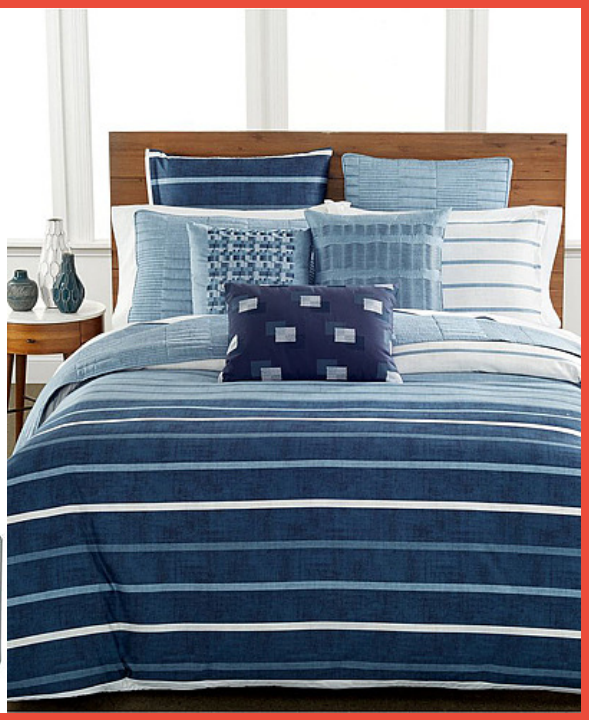
COMING TO IUP?
DO YOU NEED BEDDING?

Make your first night at IUP comfortable! Purchase now and your bedding will be waiting for you!



dorm co.com





Step 1: Login to www.DormCo.com/IUP
Step 2: Create an Account
Step 3: Click "bedding", add items to your cart, and check out
Step 4: Pay for your items

Living on Campus? Ship to:
IUP - OIE
920 Grant Street
Delaney Hall B25
Indiana, PA 15705

Living off Campus? Ship to: Your new Indiana, PA address. Select the date to receive your items.

*All Residence Hall bed size is TWIN XL.