Office of Student Affairs and Admissions

Health Insurance Waiver Form

Complete and Submit to Receive Health Insurance Waiver

I ______________________________ (name) do hereby certify I have at least the minimum health insurance coverage benefits listed below and required by the School.

1. Major medical coverage of at least $100,000
2. Out-patient testing reimbursement
3. Hospitalization benefits
4. Out-patient ambulatory surgery coverage
5. Mental Health benefits at a minimum of 50% reimbursement
6. Substance abuse coverage

My coverage will be in effect for the remainder of medical school, or until I become ineligible. In the event it is terminated, I will inform the School within 30 days.

At the present time, I am covered by the following health insurance.

Insurance Company or Carrier
Policy Number
Address
Phone
Are you covered under a parent or spouse?
If this coverage will terminate prior to graduation, provide date.

The information submitted to the School should be complete and correct to the best of your knowledge. In the event pertinent changes occur in your coverage, please notify the School immediately.

______________________________ ________
Signature Date

____
Print Name

Please attach a copy of your insurance card and submit this form to Ms. Dee Wilcox, Office of Student Affairs and Admissions, 190 White Hall.