Boonshoft School of Medicine
WRIGHT STATE UNIVERSITY
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 BSOM.

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 my insurance is terminated or changes, **I will inform the Student Health Insurance office within 30 days.**

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

Insurance Company or Carrier:	
Policy Number:	
Claims Address:	
Phone:	
Are you covered with a: (circle one)	SPOUSE PARENT
Provide date of termination, if known:	

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

_____ _____

Signature Date

_____ _____

Print Name University UID#

Please attach a copy of your insurance card and submit this form to Nancy Caupp, Office of Student Affairs, Student Insurance office, 051D Student Union