CHSU CALIFORNIA HEALTH SCIENCES UNIVERSITY

Academic Year: _____

CHSU STUDENT HEALTH PLAN WAIVER

INSTRUCTIONS:

- **Please complete this form and submit it to the Registrar with a copy of your insurance card**
- **All fields on this form are required**
- **Please notify your Registrar if you have any difficulties completing your waiver request**

STUDENT INFORMATION:

Student ID: _____

First Name: _____

Last Name: _____

E-mail Address: _____
A functional e-mail address for receiving updates of your waiver status.

Phone: _____
Please enter a phone number above where you can be reached 8 a.m. - 4:30 p.m., Monday-Friday. (Enter as XXX-XXX-XXXX)

INSURANCE INFORMATION:

PETITION FOR WAIVER OF SCHOOL-SPONSORED STUDENT HEALTH PLAN.
I certify that I will be participating in the following comparable health insurance plan during the academic year indicated below. I accept responsibility for my insurance being comparable to the school-sponsored plan. I further understand that by submitting this waiver request, I will be responsible for my medical expenses and neither the school nor its health insurance program will be responsible for my medical expenses. I understand that it is my responsibility, if there is any change in my health coverage, to notify the school and complete a new waiver form.

I am declining: ☐ Medical coverage

_____ NAME OF INSURANCE COMPANY (CARRIER)

_____ INS. COMPANY CUSTOMER SERVICE PHONE NO.

_____ NAME OF POLICYHOLDER

_____ POLICYHOLDER'S RELATIONSHIP TO STUDENT

_____ ID OR POLICY NUMBER

_____ GROUP NUMBER

_____ SIGNATURE OF STUDENT

_____ DATE

Revised 11/19/14