Jacksonville University
WAIVER FORM
STUDENT HEALTH INSURANCE PROGRAM

Name: ____________________________________ Student I.D. #_________________
Social Security Number: ____
Permanent Street Address: ____
Permanent City/State/Zip: _______________________ E-Mail Address: ___________
Current Phone Number: __________________________ Date of Birth: ____________

By my signature below, and the attached front and back copy of my current health insurance card, I am indicating that I have comparable coverage and do NOT need the school-endorsed health insurance.

My current coverage is with:
Insurance Co: ________________________________ Policy/Group # ______________
Subscriber Name: ________________________ Relationship to Student: ___________

Waiver Certification:
By my submitting this waiver request, I certify that:
1. I am currently participating in the above insurance policy.
2. I will be responsible for my medical expenses and neither the University nor its health program will be responsible for those expenses.
3. I am required to maintain health insurance coverage while in attendance at Jacksonville University.
If my health insurance status changes I will notify University by either providing a new waiver form or enrolling in the University's Student Health Insurance program.

Waiver Deadline:
Fall – August 28, 2009
Spring – January 12, 2010
Summer – May 12, 2010

Student's Signature ____________________________ Date ____________________

RETURN ENTIRE SHEET WITH A PHOTOCOPY (FRONT AND BACK) OF THE INSURANCE CARD TO THE CONTROLLER'S OFFICE FOR PROCESSING BY THE DEADLINE TO HAVE THE INSURANCE CHARGE REMOVED
Email: health@ju.edu or fax (904) 256-7206 or fax (904) 256-7148.