State Univeristy of New York

Upstate Medical University

DISABILITY INSURANCE WAIVER FORM

Students who believe they are covered by an employers disability insurance policy and wish to request waiver of the disability insurance fee must complete and return this form.

IMPORTANT
YOUR WAIVER MUST BE APPROVED BY THE OFFICE OF STUDENT SERVICES BEFORE YOU PAY YOUR BILL. PLEASE ALLOW A MINIMUM OF 2 (TWO) BUSINESS DAYS FOR YOUR REQUEST TO BE REVIEWED AND APPROVED. IF YOUR FEE IS NOT WAIVED PRIOR TO THE PAYMENT DUE DATE, YOU WILL BE LIABLE FOR THE DISABILITY INSURANCE FEE. NO REFUND WILL BE GRANTED AFTER THE PAYMENT DUE DATE.

Name Social Security # Date

College Program

Reason for Waiver:

Name of Hospital/Company Holding Disability Policy:

PLEASE HAVE THE PERSON VERIFYING YOUR DISABILITY INSURANCE FILL OUT THE SECTION BELOW.

I, (Name of person verifying disability insurance) verify that (Student's name) is covered by disability insurance. This policy will cover him/her during classes or clinical courses at Upstate Medical University for 2008-2009.

Signature Title Date

Return Form to: **Office of Student Services, Room 202, Campus Activities Building**
155 Elizabeth Blackwell Street, Syracuse, NY 13210
Telephone: 315- 464-8855

Student Service Office Use Only:

Approved by: ______________________ **Date:** __________