Cooper Medical School
of Rowan University

Health Insurance Waiver Form

I hereby waive my rights to participate in the health insurance coverage offered by CMSRU under the Rowan University Student Medical Plan. I have comparable coverage under the following plan:

Insurance Company: ____

Policy or Group # ____

This plan will:

- Cover services at Cooper University Hospital as a preferred provider.
- The co-pay for office visits does not exceed $25. Anything in excess of that will be my responsibility.
- Coverage will be in effect by 8/1/14

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at CMSRU.

Rowan ID Number : ____

Name : ____

Signature:____

Date:___________________

CMSRU office use only: reg ________ date ____________

Please forward the form via mail, fax or email scan to:
CMSRU
Office of Student Affairs
401 South Broadway
Camden, NJ 08103
Phone: 856-361-2850
Fax: 856-361-2828
thomasj@rowan.edu