NYIT College of Osteopathic Medicine

WAIVER FORM

CAMPUS LOCATION
OLD WESTBURY

PEOPLESOFT ID

Group Insurance Program For Medical Students

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	CITY	STATE	ZIP

STUDENT E-MAIL: _____ @nyit.edu TELEPHONE NUMBER: _____

I CERTIFY THAT I HAVE AND WILL MAINTAIN IN FORCE MEDICAL INSURANCE WHICH IS EQUIVALENT OR BETTER THAN THE STUDENT GROUP PLAN(S) OFFERED TO ME AND HAVE PROVIDED THE NAME, PHONE NUMBER AND CONTACT PERSON IN THE EVENT OF AN ACCIDENT OR ILLNESS. MY CURRENT MEDICAL INSURANCE COVERAGE IS:

❑ **PARENT EMPLOYER GROUP** ❑ **SPOUSE EMPLOYER GROUP** ❑ **MEDICAID**

MEDICAL INSURANCE COMPANY NAME_____

POLICYHOLDER NAME_____

MEDICAL INSURANCE POLICY NO. _____EFFECTIVE DATE _____

MEMBER SERVICES PHONE #_____

THE FOLLOWING DEPENDENT STATUS INFORMATION OBTAINED FROM THE INSURANCE COMPANY IS REQUIRED.

I HAVE VERIFIED THAT I AM COVERED UNTIL AGE _____ AND MY COVERAGE AS AN ELIGIBLE DEPENDENT TERMINATES ON:

_____ _____ _____
Month Day Year

MEDICAID NOTICE OF ACCEPTANCE DATE: _____ _____ _____
Month Day Year

MEDICAID ANNUAL RE-CERTIFICATION MONTH: _____

I CERTIFY THAT I HAVE AND WILL MAINTAIN IN FORCE DENTAL INSURANCE WHICH IS EQUIVALENT OR BETTER THAN THE STUDENT GROUP PLAN(S) OFFERED TO ME AND HAVE PROVIDED THE NAME, PHONE NUMBER AND CONTACT PERSON IN THE EVENT OF AN ACCIDENT OR ILLNESS. MY CURRENT DENTAL INSURANCE COVERAGE IS:

❑ **PARENT EMPLOYER GROUP** ❑ **SPOUSE EMPLOYER GROUP** ❑ **MEDICAID**

DENTAL INSURANCE COMPANY NAME_____

POLICYHOLDER NAME_____

DENTAL INSURANCE POLICY NO._____EFFECTIVE DATE _____

MEMBER SERVICES PHONE #_____

THE FOLLOWING DEPENDENT STATUS INFORMATION OBTAINED FROM THE INSURANCE COMPANY IS REQUIRED.

I HAVE VERIFIED THAT I AM COVERED UNTIL AGE _____ AND MY COVERAGE AS AN ELIGIBLE DEPENDENT TERMINATES ON:

_____ _____ _____
Month Day Year

MEDICAID NOTICE OF ACCEPTANCE DATE: _____ _____ _____
Month Day Year

_____ _____
STUDENT SIGNATURE DATE

_____ _____
NYITCOM/HSAC COORDINATOR DATE

INSTRUCTION

All areas of the form must be completed with the requested information. A copy of each card, front and back must be included with the form.

FOR OFFICE USE ONLY:

Waiver Information Confirmed: ❒ Yes ❒ No Effective Date: _____

Insurer Contact: _____ Group Plan: ❒ Yes ❒ No By: _____ Date: _____