American University of the Caribbean

If the student does not intend to purchase the health plan offered by Bollinger, Inc., proof of your comparable health coverage **<u>must be provided</u>** by completing this form.

____ (_____-____-_________) is currently enrolled

Student Last Name First Name Middle Initial Social Security #

in the health insurance plan listed below.

Insurance Company Name: ________________________________ Policy Number: ________________

Subscriber Name: ________________________________ Relation to Student: ________________

____

Student Signature

____

Date

Return this completed waiver form to either (1) the Business Office (for Basic Science students), or (2) the MEAS (for Clinical Science students) on or before 9/28/07 (for the Fall Term); 2/3/08 (for the Spring Term); and 5/30/08 (for the Summer Term). **Failure To Return A Completed Waiver Form By The Dates Set Forth Above Will Result In Your Being Unable To Continue Your Education At American University Of The Caribbean And May Result In Involuntary Withdrawal From The University.**