THE UNIVERSITY OF TENNESSEE
Health Science Center

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UNIVERSITY OF TENNESSEE
GRADUATE MEDICAL EDUCATION PROGRAM

INSURANCE DISCLAIMER FORM

I hereby agree that I have been offered the Graduate Medical Education Program's Insurance Plan and have decided not to take advantage of this offer since I have similar coverage elsewhere. I also understand that I will have to provide evidence of insurability for myself and, if applicable, my dependents if I wish to enroll at a later date; and I understand acceptance is not guaranteed at that time.

(Please fill in the information below online, print, sign, and return.)

My current group coverage is as follows:

INSURANCE COMPANY NAME

GROUP POLICY NUMBER

NAME OF POLICYHOLDER (if not you)

EMPLOYER'S NAME

DATE

NAME OF RESIDENT

SIGNATURE OF RESIDENT