

**STUDENT WAIVER APPLICATION FOR ACADEMIC YEAR 2006-2007**

Wayne State University School of Medicine (WSUSOM)  
Blue Cross Blue Shield of Michigan (BCBSM) Group Health Benefits

**Student Information**

Name: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
(Please Print) Date of Birth

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WSUSOM Email: \_\_\_\_\_@med.wayne.edu WSU ID: \_\_\_\_\_

**I Hereby APPLY FOR A WAIVER From BCBSM Coverage  
for Academic Year 2006-2007**

Because I am covered under another group health plan through (please specify):

- OHIP (Canadian citizen)
- Medicaid       Military
- My spouse       My parent
- Other \_\_\_\_\_

*You will be notified whether or not a waiver has been granted.*

**Insurance Information**

Policyholder (Insured) Name: \_\_\_\_\_  
Relationship to Student (if through someone else) \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_

The information above is true and accurate to the best of my knowledge. I believe that my current health insurance coverage meets the requirements for a waiver.

I understand that WSUSOM will conduct audits of selected waivers and, if asked, I will provide all requested documentation within five (5) business days or risk termination of the waiver.

I understand that I am required to have medical school approved health insurance coverage throughout my tenure as a medical student at WSUSOM, either through the school's BCBSM plan or through alternative coverage that meets the requirements for an approved waiver. If a waiver is granted, I will immediately notify WSUSOM if my "waiver" health insurance lapses, in order that I may be enrolled in the school's BCBSM plan.

If my waiver is denied, I understand that I am required to enroll in, and will be billed for, the school's Group Health Benefits plan from BCBSM.

\_\_\_\_\_  
(Student Signature)

\_\_\_\_\_  
(Date)