

STUDENT WAIVER APPLICATION FOR ACADEMIC YEAR 2010-2011

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 for Academic Year 2010-2011

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.

If you are currently enrolled in the school's health insurance plan, you must complete this section to CANCEL that coverage: If not completed you will be responsible to pay premiums:

Social Security # _____ Date to cancel coverage: _____

Please circle your current coverage: HMO Basic Medium High

Insurance Information

Please complete this section if requesting a waiver:

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 this application is **NOT Proof of Coverage**. I understand that WSUSOM **will conduct** audits of selected waivers and, if asked, I will provide all requested documentation within five (10) business days or risk termination of the waiver.

I understand that I am required to have Medical School approved the 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)