

STUDENT WAIVER APPLICATION for academic year 2009-2010
Wayne State University School of Medicine (WSUSOM)

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 2009-2010

Because **I am covered under a GROUP health plan** through (please specify):

OHIP (Canadian citizen) Military
 Medicaid My parent (as a dependent)
 My spouse Other group policy _____

I am currently enrolled in the school's plan. Please cancel that coverage.

You may be asked to provide additional information.

Insurance Information for Waiver-Eligible, Alternate Group Coverage

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 have group health insurance coverage that meets the requirements for a waiver. I do not have an individual policy.

I understand that this application is not proof of coverage. WSUSOM will conduct audits of selected waivers and, if asked, I will provide all requested documentation within ten (10) business days or risk automatic 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 Group Health Benefits plan or through alternative coverage that meets the requirements for an approved waiver. If granted a waiver, I will immediately notify WSUSOM if my "waiver" health insurance lapses, in order that I may be enrolled in the school's 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.

(Student Signature)

(Date)