WSU School of Medicine

MEDICAL STUDENT WAIVER APPLICATION FOR ACADEMIC YEAR 2019-20

Student Name: _____

Date of Birth: _____

Address: _____

_____ APT #: _

WSUSOM Email: _____ @med.wayne.edu

WSU Student ID #: _____

I APPLY FOR A WAIVER for Academic Year 2019-20
Because I am covered under another group health plan through (please specify):

[ ] Parent

[ ] Wayne State University Student/Scholar Health Insurance (IHI) plan administered by AIG (Canadian Citizen)

[ ] Medicaid

[ ] Military

[ ] Spouse

[ ] Other: _____

YOUR INSURANCE INFORMATION from your Insurance Card:

Policyholder Name:_____

Relationship to Student (if through someone else): _____

Insurance Company Name: _____Policy Number: _____

Important - Please read and Sign below

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 information within five (5) business days or risk termination of the waiver.

I understand that I am required to have the Medical School approved health insurance 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.

Student Signature: _____ Date: _____