SAINT UGUSTINE'S UNIVERSITY

Transform, Excel, Lead

Health Insurance Waiver Form

This completed form is due by **August 31st each academic year and January 31st for the Spring Semester only.** Summer Session due dates will be to be determined based on Summer Session enrollment dates. Failure to return the completed form and proof of insurance for the year will result in **no refund** of insurance charge on the student's account and automatic enrollment in the SAU Health Insurance Plan.

Annual Period: August 1, _______ to July 31, _______ / Term: Spring/Summer: January 1, _______ to July 31, ________

Please select one: New Student ________ Returning Student ________

Students enrolled in nine or more credits per semester are required to have health insurance. The University strongly recommends that Parents and Students review their health insurance policies to ensure their policy provides coverage/benefits to the health care facilities located in the Raleigh NC/Wake County area. Coverage cost under the University's plan will be provided at a later date.

Student Information

Name: ______________________________ Student ID: ______________________________

Birth Date: ______________ Gender: _________________ Student Cell Phone Number: __________________________

Family or Guardian Emergency Contact

Name: ______________________________ Relationship: ____________ Home Phone Number: __________________

Cell Phone Number: ________________________

HEALTH INSURANCE DECLARATION

*This form and a current copy of your insurance card (front/back) or policy front page showing the period of coverage must be returned by **August 31st** each academic year and **January 31st** for the Spring/Summer term only.*

☐ I am waiving my participation because I am covered by the policy described below.

As required, I have attached a copy of my insurance card (front and back) or the front page of my policy.

Health Insurance Information / Required

Please fill in the information below

Name of Insurance Plan: ______________________ Membership or Benefit Phone Number: ______________

Subscriber's Policy Number: ______________________ Group Number: ______________________

Subscriber Name: ______________________ Student Insurance Card ID#: ______________________
(if different from subscribers policy number)

Relationship to Student: ______________________ Subscriber's Daytime Phone Number: ______________

Effective Date of Coverage: ______________________ Expiration Date of Coverage: ______________________

Is this policy an HMO insurance plan? Yes ☐ No ☐

Is this policy a PPO insurance plan? Yes ☐ No ☐

Authorization

(I)(We) hereby agree that the information contained in this document is true. (I)(We) also agree to promptly notify SAU in the event of cancellation of the above coverage, and (I)(We) realize that if (I) (We) have chosen to waive SAU Student Health Insurance Plan that the University is not liable for any health care costs incurred by (me) (the student).

______________________________ Student Signature Date

______________________________ Parent/Guardian Signature (if student under age 18) Date

______________________________ Health Department Validation/Signature Date