KAISER PERMANENTE®

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Kaiser Permanente Insurance Company

KAISER PERMANENTE STUDENT HEALTH PLAN WAIVER

PLEASE COMPLETE THIS FORM AND SUBMIT IT TO YOUR SCHOOL ADMINISTRATOR TO WAIVE COVERAGE

To complete this process, you will need the following information. Please ensure that you have accurate details regarding your current insurance coverage. Please notify your school administrator if you have any difficulties completing your waiver request.

- A functional e-mail address (for receiving updates of your waiver status)
- Name of your insurance company
- Name of the policyholder
- Required identifiers for verification purposes (may include birth date, ZIP code, or other information)
- Any plan or group numbers
- The company's customer service number

All fields on this form are required.

STUDENT INFORMATION:

Student ID_____

First Name_____

Last Name_____

E-mail Address_____

Phone_____

Please enter a phone number above where you can be reached 8 a.m.–4:30 p.m., Monday–Friday. (Enter as XXX-XXX-XXXX.)

INSURANCE INFORMATION:

PETITION FOR WAIVER OF SCHOOL-SPONSORED STUDENT HEALTH PLAN.

I certify that I will be participating in the following comparable health insurance plan during the academic year indicated below. I accept responsibility for my insurance being comparable to the school-sponsored plan, including coverage for intercollegiate and collegiate sports. I further understand that by submitting this waiver request, I will be responsible for my medical expenses beyond those supplied free of charge by the student health center and neither the school nor its health insurance program will be responsible for my medical expenses. I understand that it is my responsibility, if there is any change in my health coverage, to notify the school and complete a new waiver form.

I am declining: Medical coverage ☐ Repatriation and Medical Evacuation coverage (foreign students only) ☐

_____ NAME OF INSURANCE COMPANY (CARRIER)

_____ ACADEMIC YEAR

_____ NAME OF POLICYHOLDER

_____ POLICYHOLDER'S RELATIONSHIP TO STUDENT

_____ ID OR POLICY NUMBER

_____ DEDUCTIBLE AMOUNT OF POLICY

_____ SIGNATURE OF STUDENT

_____ DATE