

WAIVER OF HEALTH AND/OR DENTAL CARE

***Waiver Deadline is
October 15, 2009**

- You must complete and sign this form if you choose to waive health or dental benefits under your group plan
- You may waive health coverage for yourself ONLY if you have coverage through a comparable health plan.
- You must attach proof of health coverage with this form (photocopy of insurance card or a letter from the insured individual's employer, confirming your coverage).
- You may waive dental care benefits by checking the appropriate box below.
- Forms may be returned to any of the following:
Financial Services (GMH 103)
Registrar's Office (Student Services Building)
Residence Life (JDH 106)

Student ID number	Name

Group Name & Division Name/Number for alternate insurance

Employee's Name (Last/First/Middle) i.e. alternate insurance holder (spouse, parent, etc.)

Waiver of Extended Health Care Benefits
<input type="radio"/> I do NOT want Extended Health Care

Waiver of Dental Care Benefits
<input type="radio"/> I do NOT want Dental Care

I hereby waive health and/or dental benefits, as indicated above, under this group insurance plan because I have comparable coverage elsewhere.

Student's Signature

_____, 20
Date Signed

St. Thomas University

_____, 20
Date Signed

