



WESTERN
ILLINOIS
UNIVERSITY

Deadline _____

Student's Name _____

Student ID# _____

Begin Waiver ____ Fall ____ Spring ____ Sum. Year _____

STUDENT HEALTH INSURANCE WAIVER FORM

THIS WAIVER WILL BE CONSIDERED FOR ALL FUTURE SEMESTERS OF CONTINUOUS ENROLLMENT AT WIU.

INSTRUCTIONS:

1. Complete all information on this form. Please do not remove carbon copy.
2. **Present BOTH insurance ID card and a Schedule of Benefits (which is a brief outline of your coverage), including the amounts of the deductible and policy maximum. Your application cannot be processed without all requested information. Please attach photocopies if applying by mail.**
3. Return all of the above NO LATER THAN THE 10TH DAY OF THE SEMESTER (6TH DAY OF THE SUMMER SEMESTER), WHETHER OR NOT TUITION AND FEES ARE PAID.

Send to Student Health Benefits Office or Fax to (309) 298-2363
Western Illinois University
1 University Circle
Macomb, IL 61455

Name of Insurance Company _____

Policy Deductible or Co-Payment Amount _____ Benefits covered at what percent? _____

In whose name is the policy written? (Please check one.) ____ Self ____ Spouse ____ Parent

If Group Insurance, Name and Telephone Number of Employer _____

*****Students receiving an IVG (Illinois Veterans Grant), a full MAP Grant (Monetary Award Program), Teacher Shortage Grant, or Women and Minorities Grant have this insurance fee paid by the grant and are not eligible to waive the insurance fee.*****

PLEASE READ THE FOLLOWING CAREFULLY:

I certify that the above information is correct and this request will cancel my WIU health insurance for this term and all future terms for which I am continuously enrolled, unless changes occur in WIU's Student Health Benefits Policy. I understand that if I furnish false information to University officials that it is a violation of the University regulations and I may be subject to disciplinary sanctions. A waiver must be completed and submitted before the deadline, which is the 10th day of the Fall and Spring Semesters and the 6th day of the Summer Semester, whether or not tuition and fees are paid. I certify that I will be covered by the above insurance, which will REMAIN IN EFFECT THROUGHOUT MY CONTINUOUS ENROLLMENT AT WESTERN ILLINOIS UNIVERSITY. I understand that should my coverage listed above terminate, I may apply for reinstatement in the Student Health Insurance Program within 31 days of the termination by providing written documentation of the date of termination from the other insurance company to the Student Health Benefits Office. I understand that should I wish to re-enroll in the Student Health Benefits Program, I may do so by signing a reinstatement form before the 10th day of the Fall or Spring Semester (6th day Summer Semester).

STUDENT'S SIGNATURE _____ DATE _____ BIRTH DATE _____

Send Notification of Approval/Denial to the Following Address:

Name _____

Address _____

City, State, Zip _____

*****For Office Use Only*****

Approved	_____
Verified	_____
Denied	_____
Reason	_____