CABRINI COLLEGE
2010-2011

STUDENT HEALTH INSURANCE
WAIVER FORM

______________________________	______________________________	______________________________
Print Student's - Last Name	First Name	Student's ID Number

I will not be joining the student insurance plan offered through Cabrini College because I have comparable coverage through another plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the College and that the College will not be responsible for any medical expense. I will notify the Cabrini College Health Services Office if I lose my medical protection. I am currently covered under the following policy:

Insurance Company Name ______________________________ Policy #______________________________

Policy Subscriber ______________________________ Group # ______________________________

Signature ______________________________ Date _____ / _____ / _____

WAIVER FORM MUST BE RETURNED TO THE CABRINI COLLEGE HEALTH SERVICES OFFICE BY July 15, 2010.

**** * * INCLUDE A COPY OF YOUR INSURANCE ID CARD * * ****

WE ENCOURAGE YOU TO FAX THIS RESPONSE TO 610-902-8282

CABRI WF 6/10