



Calvin College Student Health Insurance Waiver Form

Name: _____ Calvin ID: _____

Calvin College requires that all undergraduate students enrolled in at least 6 credit hours carry medical insurance. Unless a waiver is submitted, students are automatically enrolled in the college-sponsored plan (KnightCare). If you are covered by other medical insurance and wish to waive the coverage offered by Calvin College, your insurance coverage must meet the criteria listed below. If you are uncertain about your insurance benefit plan, contact the company to confirm the coverage limits.

1. My plan provides coverage for the academic year, and I intend to remain enrolled in this plan for the entire academic year. YES NO
2. My plan is a major medical plan. YES NO
3. My plan provides coverage for local hospitals, physicians, pharmacies and mental health care providers in the Grand Rapids area. YES NO
4. My plan provides coverage for lab work, diagnostic x-rays, physical therapy, and prescriptions in the Grand Rapids area. YES NO
5. My insurance carrier is a company based in the United States, and hospitals and doctors will be able to bill them directly. YES NO

THE FOLLOWING INFORMATION MAY BE FOUND ON YOUR INSURANCE CARD:

Insurance Company Name _____

Company Address _____

Company Phone # _____

Policy/ID # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____

(Person who is financially responsible for payment of charges)

Policy Holder's Address _____

By submitting this form, you acknowledge that: **1)** You are currently covered by the above-mentioned plan; **2)** Your plan is NOT a travel or an emergency-only plan; **3)** You have adequate financial resources available to pay for the charges subject to the deductible and any applicable copays; **4)** You have verified your coverage within the Grand Rapids area with your health insurance plan representative; **5)** You understand that if at any time during the academic year should you lose your medical insurance coverage, you must either *a)* secure other coverage and notify Health Services of this alternative coverage or *b)* elect to enroll in KnightCare and pay the applicable premium.

Signature of Student

Date

For Office Use Only:

Date this form was received at the Health Center: _____