

KnightCare **Waiver Form**

Name: _____ Calvin ID: _____

- I AM ADEQUATELY COVERED UNDER AN EXISTING INSURANCE PLAN AND CHOOSE TO WAIVE OUT OF THE 2007-08 KNIGHTCARE PLAN.**

To choose this option I must disclose complete insurance information and answer the following questions.

QUESTIONS:

- | | | | |
|----|--|-----|----|
| 1. | My current plan provides coverage for medically necessary care in the greater Grand Rapids area and anywhere in the United States. | YES | NO |
| 2. | My plan provides coverage for the entire academic year. | YES | NO |
| 3. | My plan provides coverage for at least \$50,000 per year. | YES | NO |
| 4. | My plan covers both outpatient treatment and hospitalization for mental health problems. | YES | NO |
| 5. | My plan covers both medically necessary outpatient treatment and hospitalization for medical and surgical services. | YES | NO |
| 6. | My plan is a travel plan or an "emergency-only" plan. | YES | NO |

THE FOLLOWING INFORMATION SHOULD BE OBTAINED FROM YOUR INSURANCE CARD:

Insurance Company Name _____

Company Address _____

Company Phone # _____

Policy # _____ Group # _____

Policy Holder Name _____
Name of the person who is financially responsible for payment of charges

Policy Holder Address _____

Primary Care Provider _____
If unknown, enter NA

***ALL STUDENTS WHO DO NOT RETURN THIS FORM BY OCTOBER 1ST
WILL BE AUTOMATICALLY ENROLLED IN KNIGHTCARE***

Calvin College Health Services, Immunizations and Insurance, 3200 Knight Way SE, Grand Rapids, MI 49546
Phone: (616) 526-6568 Toll-free: (800) 688-0122 (option 8) Fax : (616) 526-8818
E-mail: health@calvin.edu Web: <http://www.calvin.edu/admin/health/>

<p>For Office Use Only: Date this form was received at the Health Center: _____</p>
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