

# **Student Health Insurance Waiver Form**

Name: \_\_\_\_\_ Calvin ID: \_\_\_\_\_

- I AM ADEQUATELY COVERED UNDER AN EXISTING HEALTH INSURANCE PLAN AND CHOOSE TO WAIVE OUT OF THE STUDENT HEALTH INSURANCE 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 |
| 7. | My current 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 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

Primary Care Provider \_\_\_\_\_

If unknown, enter NA

***ALL STUDENTS WHO DO NOT SUBMIT THIS FORM BY OCTOBER 1ST  
WILL AUTOMATICALLY ENROLLED IN THE STUDENT HEALTH INSURANCE  
PLAN***

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](mailto:health@calvin.edu) Web: <http://www.calvin.edu/admin/health/>

**For Office Use Only:**

Date this form was received at the Health Center: \_\_\_\_\_