



## WAIVER CARD STUDENT HEALTH INSURANCE

*Please Print*

Student's Name \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Student's Address \_\_\_\_\_

Berkeley Location \_\_\_\_\_ Program \_\_\_\_\_ Start Date \_\_\_\_\_

Attending:     Day         Evening/Weekend

I will not be joining the Student Health Insurance Plan for the current academic year because I have coverage comparable to the health benefits of the College Plan through my own or my family's membership in the following group or private policy.

Name of Insured \_\_\_\_\_ Relation to Student \_\_\_\_\_

Name of Insurance Co. or Group \_\_\_\_\_ Policy # \_\_\_\_\_

Address of Company \_\_\_\_\_ Date of Expiration \_\_\_\_\_

I fully understand that I am legally responsible for any medical expense incurred during my enrollment at Berkeley College and the College will not be responsible for any medical expense.

Date \_\_\_\_\_ Signature \_\_\_\_\_

THIS FORM MUST BE SUBMITTED BEFORE THE END OF THE ADD/DROP PERIOD TO AVOID PAYING THE COST OF THE INSURANCE.