

# Request for waiver of participation in \_\_\_\_\_ student health insurance program 2007-08

## Student information

Name \_\_\_\_\_ Reed ID # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## Policyholder information

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer or carrier \_\_\_\_\_

Insurance name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone number for claims \_\_\_\_\_

Individual membership # \_\_\_\_\_ Group # \_\_\_\_\_

Coverage to age \_\_\_\_\_ Exp.date \_\_\_\_\_

**I hereby represent that the benefits provided under the above policy are at least comparable to the coverage provided by the Reed College student medical program.**

**I understand that if this waiver request is approved that I will be personally responsible for all expenses incurred as a result of any accident or illness sustained while at Reed College that is not included within those services provided by the college's health facilities.**

**Signature of student, or parent or guardian (invalid without signature)**

Student signature \_\_\_\_\_ Date \_\_\_\_\_

**If student is under 18, parent or guardian signature is required**

Parent or guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**RETURN TO:** Reed College Business Office, 3203 SE Woodstock Blvd., Portland, OR 97202-8199 or fax to 503/788-6687

