



William Carey University
Request for Waiver of Group Medical Coverage
WCU Medical Professions Student Group Plan

Section 1: Student Information

Student Name:		Date of Birth: (MM/DD/YYYY)
Waiver for period: (Mark only one) <input type="checkbox"/> August - January <input type="checkbox"/> February - July	Waiver Year:	Group Name: 911607 WCU Medical Professions Student Group Plan
Student ID:	Last 4 digits of Social Security Number:	Discipline: <input type="checkbox"/> Medical School <input type="checkbox"/> Pharmacy School

Section 2: Reason for Request of Waiver

I have had the student medical benefits plan presented to me for my participation, and I understand that I must show proof of medical coverage under school accreditation guidelines and requirements. I am requesting a waiver from the required student group coverage based on one (or more) of the following qualified reasons for waiver:

Please check one or more:

- Covered under parent's insurance plan (note - only up to age 26)*
- Covered under spouse's insurance plan*
- Covered by either Medicare or Medicaid
- Other - Please explain other coverage eligible for waiver

* Provide name of carrier and policy number of alternate coverage

* A copy of a current Letter of Credible Coverage from the insurance company must be attached to the request.

Section 3: Student Signature

I understand that by requesting to be waived from the group coverage at this time, I will not be eligible to elect medical coverage until the next open enrollment period of the group's policy, or if a qualifying event occurs. I understand that qualified events must be reported to the group within 30 days of the occurrence to be eligible for changes.

I also understand that waivers will maintain in effect only for the six month period requested and must be renew in July for the August through January period, or in January for the February through July period.

Signature

Date