

**Rosalind Franklin University of Medicine and Science**

**Student Health Insurance Waiver Form  
Policy #AMH0060780**

**2009 - 2010**

**TO BE COMPLETED BY FULL TIME STUDENTS WAIVING COVERAGE**

Student Name:

\_\_\_\_\_ Last Name First Name MI

Student ID #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

REFUSAL OF COVERAGE.

Insurance Company: \_\_\_\_\_ (including Medicaid/Medicare)

Subscriber Name: \_\_\_\_\_  
Last Name First Name MI

Insurance Policy #: \_\_\_\_\_ Insurance Company Phone #: \_\_\_\_\_

By my signature, I affirm that I am currently insured under the above, comparable insurance policy and will continue to be insured throughout my attendance at RFUMS. I have therefore chosen to waive the University-sponsored Student Insurance Plan. I certify that the information supplied is correct, and I am responsible for any incorrect information, whether intentional or otherwise. I understand I am legally responsible for any medical expenses incurred during my enrollment at the University, and that the University and its medical insurance program will not be responsible for any of my medical expenses. I understand that this information may be verified, and if my plan does not meet comparable coverage requirements, or I am uninsured, I will automatically be charged for and enrolled in the Student Health Insurance Plan (PLAN B).

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

**RETURN THIS FORM ALONG WITH PROOF OF COMPARABLE COVERAGE TO:**  
ROSALIND FRANKLIN UNIVERSITY  
BUSINESS OFFICE  
3333 GREEN BAY ROAD  
NORTH CHICAGO, IL 60064