

BARRY UNIVERSITY CAMPUS RESIDENT SUPPLEMENTAL INSURANCE WAIVER

All full-time undergraduate University students residing in campus housing must participate in the health insurance program endorsed by Barry University at a cost of \$90.00 or provide the evidence of adequate health insurance as outlined below. Acceptance of this waiver will only be considered with completed information and submitted no later than **August 28, 2009 (or January 11, 2009 for students beginning their studies in the Spring semester)** to the Student Health Center office in Landon 104. A new waiver form is required each academic year.

The supplemental insurance fee of \$90.00 will not be removed from your account unless you submit this completed waiver form, have completed the primary insurance waiver (part I) and, have provided a copy of your primary insurance card to the Student Health Center prior to the first day of classes for the fall semester.

Should you lose the coverage identified below, you are expected to notify the Student Health Center immediately for appropriate modification of insurance information.

Student's Name: _____ Student ID#: _____

Home Address: _____ State: _____ Zip Code: _____ Local phone: _____

Please fill out completely:

I am adequately insured under the following health insurance (**a legible copy of both sides of my card is attached**) and I wish to waive out of the SHC supplemental insurance plan.

REQUIRED DATA

Name of Insurance Company: _____

Policy Number: _____ Insurance Company Phone: (_____) _____

Dade/Broward County Participating Physician:

Name _____ Phone# _____

Barry Vehicle Registration Number and Expiration date: _____

I have submitted proof of all required vaccinations to the Student Health Center: YES NO

By signing this waiver I am affirming that my insurance policy will provide the coverage as outlined above for the current academic year. I hereby release Barry University, Inc. of any responsibility for my health care and I will assume all financial responsibility for any medical expenses that I incur while attending Barry University. I understand that by signing this waiver I am no longer eligible for the primary care services offered in the SHC and I will seek medical services off campus. I will be entitled to limited self help, educational and referral services.

I understand that even though I have private insurance, I am eligible for the Barry University Health Plan and may enroll on a voluntary basis.

Date: _____ Student Signature: _____

Date: _____ Subscriber Signature: _____

WAIVER OF PARTICIPATION REQUEST WILL NOT BE ACCEPTED UNLESS EACH BLANK IS PROPERLY COMPLETED AND A LEGIBLE COPY OF BOTH SIDES OF YOUR INSURANCE ID CARD IS ATTACHED.

OFFICE USE ONLY: RECEIVED BY _____ ON _____

APPROVED _____ DENIED _____ REASON FOR DENIAL _____

**Mail/Fax or Deliver to:
Barry University Student Health Center
11300 NE 2nd Avenue-Landon 104
Miami Shores, Fl. 33161
Ph: (305) 899-3750 Fax: (305) 899-3751**