

BROOKDALE COMMUNITY COLLEGE

WAIVER CARD STUDENT HEALTH INSURANCE

Please Print

An Equal Opportunity/Affirmative Action Institution

Name of Insured _____ Relation to Student _____

Student's Name _____ Student I.D. No. _____

Student's Address _____

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 the College.

Date _____ Signature _____

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