

**EMMAUS BIBLE COLLEGE**  
**STUDENT INSURANCE APPLICATION OR WAIVER**

Students are expected to participate in the Student Health Insurance offered through the College unless the student is carrying comparable coverage individually or through his or her parent(s) or legal guardian. Please complete this form and return to Emmaus Bible College, Office of Student Accounts. A return envelope is enclosed for your convenience. **Failure to return this form by Monday, December 1, 2008, means you will be automatically enrolled in the health insurance plan.**

**ALL STUDENTS, PLEASE COMPLETE THE FOLLOWING:**

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
**Date:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Check one of the selections below:**

- \_\_\_\_\_ I desire to be enrolled in the health insurance plan, as I do not have coverage elsewhere. Please bill my account for \$355, the PRO-RATED annual premium, for coverage beginning January 1, 2009 and ending August 25, 2009.
- \_\_\_\_\_ I already have other coverage and do not want this plan. ***Please complete waiver form at bottom of page.***

**DEPENDENT COVERAGE**

If you wish to include members of your family (spouse and/or children) in the insurance program offered by Emmaus Bible College, please contact the Business Office.

**OTHER**

It is the responsibility of the student to notify the College of any changes regarding insurance coverage needs.

**This form must be returned to the Business Office by Monday, December 1, 2008.**

----- do not tear or cut sheet -----

**STUDENT HEALTH PLAN WAIVER**

**PLEASE COMPLETE SECTION BELOW ONLY IF WAIVING COVERAGE THOUGH THE COLLEGE**

Student Name \_\_\_\_\_ Date \_\_\_\_\_

*Please review the information above carefully. If this waiver form is not returned, you will automatically be enrolled in the health insurance plan.*

I wish to waive coverage under the Student Health Insurance Plan by completing the following Student Health Insurance Waiver. I currently have other coverage and have provided the information below. Therefore, please do not add the charge for this insurance to my bill. I fully understand that I am legally responsible for any medical bills incurred during my enrollment at the college and that the college will not be responsible for any medical expenses I incur. I am currently covered under the policy listed below which meets or exceeds benefits listed in this Brochure, including coverage for injuries sustained while participating in any interscholastic, club, intercollegiate, or professional sport, contest or competition. I understand I must provide written proof of these benefits in order to qualify for a waiver.

**INFORMATION ABOUT CURRENT HEALTH INSURANCE COVERAGE:**

**Insurance Company Name:** \_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_

**Insurance Company Phone #:** \_\_\_\_\_

**Policy #** \_\_\_\_\_ **Group Plan** \_\_\_\_\_ **OR Private Plan** \_\_\_\_\_ *(PLEASE CHECK ONE)*

**Signed:** \_\_\_\_\_ **Student's S. S. #** \_\_\_\_\_