



WAIVER FORM

DUE JANUARY 8, 2006

IMPORTANT NOTICE REGARDING WAIVER

Notre Dame de Namur University requires that all RESIDENTS, FULL-TIME UNDERGRADS AND INTERNATIONAL STUDENTS have accident and sickness insurance. The \$524 SPRING Premium will be included on your billing statement unless this waiver form is completed and returned to Health & Wellness Services. Students with comparable coverage may waive out of the NDNU Insurance Plan if this signed waiver form is submitted to Health & Wellness Services by **January 8, 2006. "Comparable Coverage" means that the policy meets the following criteria:**

- No greater than \$1000 deductible
- No less than \$50,000 medical maximum per injury or sickness
- Coverage must include pregnancy benefits
- Coverage area includes San Francisco Peninsula
- Coverage must not be for Emergency Care only
- Coverage must meet state and federal benefit mandates
- Coverage must be extend through academic year

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|---|
| PLEASE CHECK ALL THAT APPLY |
| <input type="checkbox"/> NEW |
| <input type="checkbox"/> RENEWING |
| <input type="checkbox"/> DOMESTIC |
| <input type="checkbox"/> INTERNATIONAL |
| <input type="checkbox"/> GRADUATE |
| <input type="checkbox"/> UNDERGRAD |
| <input type="checkbox"/> PRAC. TRAINING |
| <input type="checkbox"/> RESIDENT |
| <input type="checkbox"/> FEMALE |
| <input type="checkbox"/> MALE |

I WAIVE 2005-2006 NDNU STUDENT INSURANCE ENROLLMENT AS MY POLICY MEETS THE CRITERIA LISTED ABOVE:

| | | | |
|--------------------------------------|--|----------------------|---------------------|
| _____ | | _____ | _____ |
| INSURANCE COMPANY | | POLICY NUMBER | EXP DATE (if noted) |
| STUDENT'S NAME _____ | | DATE OF BIRTH _____ | |
| STUDENT I.D. # _____ | | | |
| PERMANENT U.S. MAILING ADDRESS _____ | | | |
| | | Street | City |
| PHONE NUMBER _____ | | E-MAIL ADDRESS _____ | |
| | | State Zip | |
| VISA TYPE (F-1, J-1 ETC.) _____ | | HOME COUNTRY _____ | |

By my signature I agree that the above statements are true and agree to immediately notify Health & Wellness Services of any changes in my contact information or my health insurance policy/coverage. Waiver is valid for 2005-2006.

Print Name _____ Date _____

Student Signature _____

Underwritten by:
Combined Insurance Company of America
Philadelphia, PA

If your health insurance plan does not meet the above criteria, you will be automatically enrolled in the Spring 2006 NDNU International and Domestic Student Accident & Sickness Insurance Plan. A NEW WAIVER FORM must be submitted in the Fall 2006 semester or after a break in academic studies.

**Return by January 8, 2006 to: HEALTH & WELLNESS SERVICES, NDNU, 1500 RALSTON AVE, BELMONT, CA 94002
PHONE: 650.508-3756 FAX: 650.508.3475**

To Enroll in NDNU Accident & Illness Plan, Download Form at www.ndnu.edu/student-services/health.html