

ROWAN UNIVERSITY
2008-2009 Academic Year
Request for Waiver of Student Medical Insurance

Student's Name _____ Rowan ID# _____
(Please Print: Last, First, Middle Initial)

Student's Address _____
(City, State, Zip)

I hereby waive my rights to participate in the insurance coverage offered under the student medical plan. I have comparable coverage under the following plan.

Name of Insurance Co. or Group _____ Policy or Group # _____

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Rowan University.

Date _____ Signature _____

FULL-TIME STUDENTS MUST FILE THEIR INSURANCE WAIVER FORM WITHIN 21 DAYS FROM THE START OF THE SEMESTER OR THEY WILL BE CHARGED FOR THE STUDENT INSURANCE PLAN AND BE RESPONSIBLE FOR THE ANNUAL PREMIUM.