RESIDENCE HALL & INTERNATIONAL STUDENT HEALTH INSURANCE WAIVER FORM
ADELPHI UNIVERSITY 2008–2009

Print Student's - Last Name ______________________ (First Name) ______________________ (Student ID Number) ______________________

I will not be joining the student insurance plan offered through Adelphi University because I have comparable coverage through another plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the University and that the University will not be responsible for any medical expense. I will notify the Adelphi Health Service Center if I lose my medical protection. I am currently covered under the following policy:

Insurance Company Name ______________________ Policy # ______________________

Copy of Insurance Card required for Waiver

Name and telephone number of physician under your policy that will care for you in the Garden City, New York area:

Physician's Name ______________________ Physician's Phone ______________________

Student/Parent Signature ______________________ Date ______________________

WAIVER FORM MUST BE RETURNED TO THE ADELPHI UNIVERSITY HEALTH SERVICE CENTER BY OCTOBER 5, 2008.

M9A00 (WC)