

Request for waiver of participation in student health insurance program 2009–10

Name _____ Reed ID _____

Address _____

City _____ State _____ Zip _____

Policyholder name _____

Employer or carrier _____

Insurance name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone number for claims _____

Individual membership number _____ Group number _____

Coverage to age _____ Expiration date _____

I hereby represent that the benefits provided under the above policy are at least comparable to the coverage provided by the Reed College student medical program.

I understand that if this waiver request is approved I will be personally responsible for all expenses incurred as a result of any accident or illness sustained while at Reed College that is not included within those services provided by the college's health facilities.

Signature of student, or parent or guardian (invalid without signature)

Student signature _____ Date _____

If student is under 18, parent or guardian signature is required

Parent or guardian signature _____ Date _____