

MIAMI UNIVERSITY WAIVER FORM

School Year 2008-2009

Student Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Student ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

Parent Email Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_

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

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

Insurance Company Phone Number: \_\_\_\_\_

Agreement

- I understand the mandatory insurance requirement at Miami University and agree to maintain coverage during my studies at Miami University. I agree to be responsible for advising Miami University Student Health Service in writing of any lapses or cancellations of this policy during any semester for which I am enrolled. I authorize the University and/or its representative to obtain eligibility verification and benefit information as necessary to process this waiver request.

PLEASE MAIL FORM TO: STUDENT HEALTH SERVICE  
421 S. CAMPUS AVE.  
OXFORD, OHIO 45056

OR FAX TO: 513 529-1892

