



**Deadline:**  Fall/Spring\* Sept. 15, 2010  
 Fall Sept. 15, 2011  
 Spring Jan. 25, 2011  
 \*You may waive both semesters in Fall

Student Health & Wellness Center  
 Phone: (707) 654-1170

**Mail Forms to:** The California Maritime Academy  
 Student Health & Wellness Center  
 200 Maritime Academy Dr.  
 Vallejo, CA 94590

**NO FAX COPIES OR EMAILED FORMS ACCEPTED!**

**Medical Insurance Fee Waiver Form**  
**Academic Year 2010-2011**

**INSTRUCTIONS:**

1. Select the semesters you choose to waive. To waive the entire academic year, place a check mark in the Fall/Spring box at the top right-hand corner of this form.
2. Complete Sections A, B, & D
3. **Attach a copy of the front and back of your medical insurance card.** Waiver forms and cards received must be received together.
4. Keep a copy of the completed form for your records.
5. Mail or bring the completed form and copy of insurance card to the Student Health & Wellness Center.

*A NEW WAIVER FORM MUST BE COMPLETED AT THE BEGINNING OF EACH ACADEMIC YEAR.*

If you miss the deadline, the fee will not be waived and you will be responsible for purchasing the plan for the semester!

**Section A: Student Information**

<b>Student ID #:</b>										E-mail Address:
Last Name	First Name	M.I.							Date of Birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Permanent Address			City	State	Zip	Telephone Number			<input type="checkbox"/> Cell <input type="checkbox"/> Home	

☞ Students should always carry their Medical Insurance Card with them ☞

Using the toll-free member service telephone number on your insurance card, contact your insurance company for any information necessary to complete section B of this form in order to ensure that your policy compare insurance requirements in Section C.

**Section B: Medical Insurance Information** – Waivers with incomplete information will not be accepted

*** Medical Insurance Information ***		
Name of Medical Insurance	Billing Address	Contact Phone Number
Subscriber's Name	Subscriber's Relationship to Student	
Subscriber's ID #	Group #	Policy #
Local Primary Care Physican (within 50 miles of campus)		Physician's Address
Physican's Phone Number		Office Use Only

**Section C: Student Medical Insurance Benefits and Minimum Insurance Requirements to Waive** – Current coverage must meet requirements below

- Maximum lifetime benefit of \$100,000 per injury or illness
- Mental Health Coverage of 12 days at 80% in network/ 50% out of network
- Annual deductible is equal to or less than \$500 per year
- 80% in network/ 50% out of network coverage for Hospitalization/ Professional fees
- World Wide Coverage
- Policy includes benefits for all mandated benefits in California
- All HMO plans must have a local primary care doctor within 50 miles of the campus community

**Section D: Certification**

I hereby certify that the above policy meets or exceeds the above minimum benefit requirements and will remain valid for the remainder of this academic year. I understand and agree that, if I am granted a waiver, I must maintain comparable health insurance at all times during this waiver period. I understand and agree that if my health insurance coverage is terminated, I must immediately notify the Student Health & Wellness Center to reverse my waiver; show proof of new coverage, or purchase the endorsed plan, as it is my responsibility to maintain continuous medical insurance coverage. I understand that I may be randomly selected for a full policy review.

Student's Signature	Date
---------------------	------