

OPT-OUT APPLICATION & WAIVER FORM



Extended Health & Dental Benefits including Accident Insurance

I am fully aware that I must include, with this application, proof of alternate coverage as listed below.

STUDENT STATEMENT

RWAM Group # 490009	Name of Student	Student I.D.#
Student Address, while at school	Date of Birth (yy/mm/dd)	
	Telephone #	
	Email Address	
	International Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
Opting Out Of: <input type="checkbox"/> Extended Health Care & Dental Benefits <input type="checkbox"/> Extended Health Care Benefits Only <input type="checkbox"/> Dental Benefits Only		

CANADIAN MEDICAL WAIVER

Name of Company Providing Alternative Coverage	Policy Number	Expiry Date
Policy Holder's Name		
September enrolment <input type="checkbox"/> January enrolment <input type="checkbox"/> Summer enrolment <input type="checkbox"/>		

Please include:

- A photocopy of parent's/spouse's Drug Benefit Card, or
- A letter from the insurance company/benefits administrator indicating the type of coverage, name of insurance company, and name of insured, or
- Copy of Indian Status Card or Government Assistance Health Plan Card

If you opt-out prior to September 25, 2010, upon receipt of your opt-out form you will receive email verification. Please contact the Health Plan Office if you do not receive verification of your opt-out. To verify the processing of your opt-out application, please check student self-service via the Registrar's web page.

Authorization:

I understand that in order to obtain a refund, all correspondence must be received by the SMUSA Health Plan Office by September 25, 2010. Having read the Extended Health and Accident Insurance Plan Information, I understand and agree that the SMUSA has provided me with sufficient information for making an informed and responsible decision. I understand that the program I am declining to participate in may not be similar to the program that I am covered under at this present time. I also understand that I may be eligible to claim under both programs and may realize further benefits by not declining this health plan. I further understand that having opted out of the SMUSA Extended Health and Accident Insurance Plan that I am not eligible under any circumstance to opt back into the plan for the coverage term between September 1, 2010 through to August 31, 2011.

Signature of Student _____

Date _____

Privacy Note:

This form is for internal use, but may be provided to the insurer, if proof of the student's opt-out is required. The information collected is used solely to ensure that the student who chooses to opt-out of this plan is refunded their premium, and as proof of opt-out. The contact information will only be used by the SMUSA Health Plan office in the event it is necessary to contact the student.

APPLICATION MUST BE SUBMITTED BY
September 25, 2010 or
January 21, 2011 (2nd Term Enrollments)

To: SMUSA STUDENT HEALTH PLAN OFFICE
 Room #529, 5th Floor, Student Centre, 923 Robie St., Halifax, NS B3H 3C3
 Email: healthplan.smusa@smu.ca Tel. (902) 496-8754

NO EXTENSIONS OR EXCEPTIONS

FOR SMUSA HEALTH PLAN OFFICE USE ONLY

Date Opt-in Received _____	Initials of Receiver _____
Accepted <input type="checkbox"/> Declined <input type="checkbox"/> Reason for Decline _____	

