

**THE CLEVELAND INSTITUTE OF MUSIC**  
**STUDENT MEDICAL PLAN INSURANCE WAIVER FORM**  
**FALL 2008 & SPRING 2009**

**Dated Material**  
**Please Read**

THIS IS NOT AN ENROLLMENT FORM. This waiver form must be signed and submitted if you do not wish to be covered by the Student Medical Plan. This form must be returned to the CIM Business Office by **September 5, 2008 for the Fall Semester or full academic year; or by January 23, 2009 for the Spring Semester.** WAIVER FORMS RECEIVED AFTER THESE DATES WILL NOT BE PROCESSED WITHOUT THE FULL COMPLIANCE OF THE UNIVERSITY HEALTH SERVICE .

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Student # from ID Card **OR** Social Security # \_\_\_\_\_

I have read and understand the details of the "Case Western Reserve Student Medical Plan" and wish to waive the plan for:  
 Fall 2008 Semester  Spring 2009 Semester (CHECK EACH SEMESTER FOR WHICH YOU WISH TO BE CONSIDERED FOR WAIVER)

***International Students:** Eligibility for waiver of the Student Medical Plan requires that your alternative health insurance coverage includes provisions for "medical evacuation" and "repatriation."*

I understand I may waive the plan only if I have medical coverage other than that provided by the CWRU Student Medical Plan, and I hereby represent that I have such coverage with:

\_\_\_\_\_  
(Name and address of Insurance Company)

Policy and/or Group # \_\_\_\_\_

By signing this waiver form, I confirm that I have medical coverage other than that provided for by the Student Medical Plan. I understand I will not be covered by the Student Medical Plan for the applicable indicated semester if I sign and submit this waiver by the applicable deadline. Upon acceptance of the waiver form by the Business Office, I am entitled to a refund of the Medical Plan Fee for the applicable semester(s). I understand that I will be responsible for all medical bills, expenses and other losses resulting from any accident or sickness incurred during the above indicated term of enrollment at the conservatory except for certain services provided by the University Health Service to students regardless of their participation in Medical Plan.

I understand any expense for health care rendered to me after the starting date of the above-indicated semester but prior to the effective date of this waiver is my responsibility.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Home Address/City/State/Zip Code

If under 18, parent/guardian must sign \_\_\_\_\_

\_\_\_\_\_  
Date

**IMPORTANT:** Incomplete waiver forms cannot be accepted and will not be effective. Should you waive the Student Health Plan, but suffer a change in personal or family circumstance by which you lose coverage, you may request to have insurance reinstated. Determination of such change of status is determined by the University Health Service.

Office Use Only: Date Received: \_\_\_\_\_