



ECKERD COLLEGE

Health Insurance Waiver Card

We have read the descriptive material and **do not** wish to enroll the below-named student in the Supplemental Accident and Sickness Insurance offered by Eckerd College. We understand that we will be financially responsible for all medical claims incurred by the student named below.

_____, a full-time registered student at
(Student Name) (Eckerd ID)

Eckerd College is covered by medical insurance under Policy/Certificate# _____

as provided by _____
(Name of Insurance Company) (Telephone)

(Insurance Company Address)

in the name of _____
(Signature of Parent/Guardian/Spouse) (Telephone)

This waiver form must be completed, signed and returned to Eckerd College by August 9, 2008 or the coverage will NOT be waived. Failure to return the form by August 9, 2008 will cost you \$135 for Domestic students and \$575 for International students (**Non-Refundable**).