

**UNIVERSITY OF MARYLAND BALTIMORE  
2006-2007 HEALTH INSURANCE WAIVER FORM**

(Please complete in full; ***all fields REQUIRED.*** Do not separate copies until ***APPROVED*** by Student and Employee Health Center. Retain pink copy with ***VERIFIER'S INITIALS AND APPROVAL DATE*** for future reference.)

NAME: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

Return completed and signed form to:

**Student and Employee Health  
ATTN Finance Department  
29 S. Paca Street  
Baltimore, MD 21201  
(410) 328-6792**

**IF YOU CLAIM TO HAVE COMPARABLE INSURANCE, THE FOLLOWING PROOF IS NEEDED:**

1. The original or photocopy (both sides) of your insurance card.
- AND**
2. A detailed description of the plan or a list of benefits may be required.

THIS MUST BE DONE **EACH** ACADEMIC YEAR BEFORE THE BEGINNING OF THE FALL SEMESTER.

All full-time students are automatically billed for the UMB student policy (please see your student handbook for more information). To waive the UMB policy, you must show proof of comparable insurance prior to **AUGUST 25, 2006** for **CONTINUING** students or **SEPTEMBER 15, 2006** for **NEW** students for the fall semester, and **FEBRUARY 15, 2007** for the spring semester.

**\*\* ATTENTION \*\***

**PER SENATE BILL #350, THERE ARE NO EXCEPTIONS IF YOU MISS THESE DEADLINES.**

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY STUDENT AND EMPLOYEE HEALTH CENTER BELOW:**

Insurance Type \_\_\_\_\_

Verifier's initials \_\_\_\_\_ Date approved \_\_\_\_\_

STUDENT ACCOUNTS-WHITE COPY   STUDENT HEALTH-YELLOW COPY   STUDENT-PINK COPY

Esar _____
Init _____