Samuel Merritt College Student Plan

WAIVER FORM
Blue Cross of California
Group Insurance Program For Medical
and Allied Health Students

LAST NAME     FIRST NAME     M.I.

I CERTIFY THAT I HAVE AND WILL MAINTAIN IN FORCE MEDICAL INSURANCE WHICH IS EQUIVALENT OR BETTER THAN THE STUDENT GROUP PLAN(S) OFFERED TO ME AND HAVE PROVIDED THE NAME, PHONE NUMBER AND CONTACT PERSON IN THE EVENT OF AN ACCIDENT OR ILLNESS. MY CURRENT MEDICAL INSURANCE COVERAGE IS:

☐ PARENT EMPLOYER GROUP ☐ SPOUSE EMPLOYER GROUP ☐ MEDICAID
☐ MY EMPLOYER GROUP ☐ COBRA ☐ VETERANS BENEFITS

MEDICAL INSURANCE COMPANY NAME______________________________________________________________

POLICYHOLDER NAME______________________________________________________________________________

MEDICAL INSURANCE POLICY NO. ____________________________________________ EFFECTIVE DATE _____________________________

MEMBER SERVICES PHONE #____________________________________________________________________________

THE FOLLOWING DEPENDENT STATUS INFORMATION OBTAINED FROM THE INSURANCE COMPANY IS REQUIRED.

I HAVE VERIFIED THAT I AM COVERED UNTIL AGE ___________ AND MY COVERAGE AS AN ELIGIBLE DEPENDENT TERMINATES ON:

____________________________________  __________________________  ___________________________
Month                                                        Day                                                Year

MEDICAID NOTICE OF ACCEPTANCE DATE:______________________________________  __________________________  ___________________________
Month                                                        Day                                                Year

MEDICAID ANNUAL RE-CERTIFICATION MONTH:________________________________________

I CERTIFY THAT I HAVE AND WILL MAINTAIN IN FORCE DENTAL INSURANCE WHICH IS EQUIVALENT OR BETTER THAN THE STUDENT GROUP PLAN(S) OFFERED TO ME AND HAVE PROVIDED THE NAME, PHONE NUMBER AND CONTACT PERSON IN THE EVENT OF AN ACCIDENT OR ILLNESS. MY CURRENT DENTAL INSURANCE COVERAGE IS:

☐ PARENT EMPLOYER GROUP ☐ SPOUSE EMPLOYER GROUP ☐ MEDICAID
☐ MY EMPLOYER GROUP ☐ COBRA ☐ VETERANS BENEFITS

DENTAL INSURANCE COMPANY NAME____________________________________________________________________

POLICYHOLDER NAME______________________________________________________________________________

DENTAL INSURANCE POLICY NO.________________________________________________________ EFFECTIVE DATE _____________________________

MEMBER SERVICES PHONE #____________________________________________________________________________

THE FOLLOWING DEPENDENT STATUS INFORMATION OBTAINED FROM THE INSURANCE COMPANY IS REQUIRED.

I HAVE VERIFIED THAT I AM COVERED UNTIL AGE ___________ AND MY COVERAGE AS AN ELIGIBLE DEPENDENT TERMINATES ON:

____________________________________  __________________________  ___________________________
Month                                                        Day                                                Year

STUDENT SIGNATURE ___________________________________________ DATE _____________________________

AGENT/BENEFIT COORDINATOR ______________________________________ DATE _____________________________
INSTRUCTION

All areas of the form must be completed with the requested information. A copy of each card, front and back must be included with the form.