WASHINGTON ADVENTIST UNIVERSITY

Health Insurance Waiver Form 2020-2021

Student Name:_____SSN#:_____

☐ I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the University and that the University will not be responsible for any medical expenses. I am currently covered by the following policy:

Insurance Company Name:_____Policy #:_____

Signature:_____Date: _____

Important: Please bring a copy of your insurance card (Front and Back of Card) and/or have your card available to be copied.

STUDENT LIFE:

Signature: _____ Date: _____