



WASHINGTON

ADVENTIST UNIVERSITY

Health Insurance Waiver Form 2023-2024

Student Name: _____ SS#: _____

- ☐ 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 and/or have your card available to be copied.

STUDENT LIFE:

Signature: _____

Date: _____