THE JOHNS HOPKINS UNIVERSITY
STUDENT HEALTH INSURANCE
WAIVER FORM

STUDENT DATA: (Complete all requested information)

Last Name _____ First Name _____ MI _____

Date of Birth _____ (mo. day year) Hopkins ID _____ Male ☐ Female ☐

ADDRESS:

Street _____

City _____ State ___ Country _____ Zip/Postal Code _____

STUDENT DATA: (Check appropriate boxes)

Status: ☐ Undergraduate ☐ Graduate ☐ Post-doc ☐ Other

☐ International Student Scholar

Visa Code _____ (e.g. F1,J1), Home Country _____

☐ U.S./Domestic Student

Campus: ☐ Homewood

ALTERNATE HEALTH COVERAGE INFORMATION: (Please complete the following information.)

Health coverage is provided under:

Policy # _____ Insurance Co. Name _____

Certificate # _____ Phone Number and address for Claims _____

A COPY OF YOUR CURRENT HEALTH INSURANCE CARD MUST BE SUBMITTED WITH THIS WAIVER FORM.

Please list the following plan information, if applicable:

Medical Maximum _____ (i.e., $50,000, $250,000, et.)

Deductible, if applicable _____ (i.e., $100, $500, etc.)

Check One: ☐ I am covered as a dependent on this policy which is issued to _____

☐ This policy is issued in my name;

☐ Other _____

(Please provide descriptive information of plan of health coverage)

I have read the information describing the Student Health Insurance Plan offered through the University, and request WAIVER of this requirement. I certify that I have equivalent or better coverage through another plan of insurance and that information provided is current. When I waive purchase of The Johns Hopkins Student Health Insurance Plan, I understand this means **I WILL BE RESPONSIBLE FOR ANY MEDICAL EXPENSES WHICH I MAY INCUR.**

Signature: _____ Date _____

Return to: Office of the Registrar, 75 Garland Hall, 3400 N. Charles St., Baltimore, MD 21218