

NO

NO

**UNIVERSITY OF MASSACHUSETTS LOWELL – FALL 2003
REQUIRED STUDENT HEALTH INSURANCE SELECTION FORM**

This Selection Form **MUST** be completed by the beginning of **EACH** academic year that the student is enrolled at the University, **even if one was completed the year before.**

DUE DATE FOR ALL FORMS: August 22, 2003

My parent's/my own insurance information is:

I am **WAIVING** the University Health Plan. I have my parent's/my own comparable coverage as required by state law.

NAME OF INSURANCE COMPANY(CARRIER)

POLICY NUMBER

LAST NAME FIRST NAME M.I.

NAME OF SUBSCRIBER RELATION TO SUBSCRIBER

STREET ADDRESS APT. NUMBER

I certify that the above named policy, in which I am currently participating is comparable to the University health plan and will continue to be maintained during this academic year
I further understand that by submitting this waiver I will be responsible for my medical expenses and neither the University nor its insurance program will be responsible for those expenses

CITY OR TOWN STATE ZIP CODE

STUDENT IDENTIFICATION NUMBER DATE OF BIRTH

PLEASE RETURN ALL NO SELECTION FORMS TO:

Harriet Rocheleau, Student Insurance Administrator
University of Massachusetts Lowell
883 Broadway Street, Room 102, Dugan Hall Lowell, MA 01854-5110

SIGNATURE OF STUDENT(AND PARENT IF A MINOR) DATE

PLEASE MAKE A COPY FOR YOUR RECORDS.