SOCIETY OF GRADUATE STUDENTS
OPT-OUT APPLICATION & WAIVER FORM

Extended Health, Dental & Accident Insurance Program

I am fully aware that I must include, with this application, proof of alternate coverage as listed below.

STUDENT STATEMENT

RWAM Group # 490010	Name of Student	Student I.D.#
Date of Birth (yy/mm/dd)	Telephone #	
University Department/Program	Email Address	
Opting Out Of: ☐ May – August term		

Please include:

- A photocopy of a wallet certificate indicating: 1) type of coverage (e.g., health/dental) 2) name of student, 3) name of insurance company/provider, 4) policy number and 5) expiration date/period of coverage,

OR

- A letter or fax from the insurance company/provider indicating: 1) type of coverage (e.g., health/dental) 2) name of student, 3) name of insurance company/provider, 4) policy number and 5) expiration date/period of coverage,

OR

- A photocopy of Indian Status Card or Government Assistance Health Plan Card.

Authorization:

I understand that in order to be reimbursed, all correspondence must be received by the SOGS Office by 4 pm on May 29, 2009.

- Having read the Extended Health, Accident & Dental Insurance Plan information provided, I understand and agree that SOGS has provided me with sufficient information for making an informed and responsible decision.
- I understand that the program I am declining to participate in may not be similar to the program that I am covered under at this present time. I also understand that I may be eligible to claim under both programs and may realize further benefits by not declining this health plan.
- I further understand that having opted out of the SOGS Extended Health, Accident & Dental Insurance Plan that I am not eligible to opt back into the plan for the coverage term between September 1, 2008 through to August 31, 2009.

Signature of Student ____________________ Date ____________

Privacy Note:

This form is for internal use, but may be provided to the insurer, if proof of the student's opt-out is required. The information collected is used solely to ensure that the student who chooses to opt-out of this plan is refunded their premium, and as proof of opt-out. The contact information will only be used by the SOGS Health Plan office in the event it is necessary to contact the student.

APPLICATION AND PROOF OF COVERAGE MUST BE SUBMITTED BY
May 29, 2009 at 4:00 pm

To: SOGS Office UCC 260
The University of Western Ontario
1151 Richmond St. N., London, ON N6A 3K7 Tel. 519-661-3394 Fax 519-661-3374

NO EXTENSIONS OR EXCEPTIONS

FOR SOGS OFFICE USE ONLY

Date Opt-Out Received ____________________ Initials of Receiver ____________

Accepted ☐
Declined ☐ Reason for Decline ____________________