UAB STUDENT HEALTH AND WELLNESS
Knowledge that will change your world

Student Health Services
1714 9th Ave. South
Birmingham, AL 35294

Waiver of UAB Student Health Insurance Plan

Blazer ID ________________________ B0# _______________________ Social Security Number _____________________

Email ___________________________________ Academic Year ____

SEMESTER BEGINNING: ☐ Fall Semester ☐ Spring Semester ☐ Summer Semester ☐Other ________		
LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS		
CITY	STATE	ZIP
TELEPHONE NUMBER	SCHOOL OR COLLEGE IN WHICH YOU ARE ENROLLING (CHECK ONE): ☐ Medical ☐ Dental ☐ Optometry ☐ Nursing ☐ Health Professions ☐ Public Health ☐ Graduate (Degree Seeking) ☐ International Student ☐ International Scholar/Observer	

My signature below acknowledges….

1. My major medical insurance coverage should meet the following minimum standards:
   a. Compliant with federal ACA benefits requirements
   b. From an insurance company licensed to conduct business in the U.S.
   c. Provide coverage for physicians and hospital providers in the state of Alabama
   d. Provide both inpatient and outpatient mental health
   e. Provide coverage for pre-existing conditions
   f. Provide unlimited coverage per illness or injury
   g. Provide coverage for all semesters of enrollment
2. Procedures, labs, pap smears, X-rays, prescriptions and referrals ordered by Student Health Services providers are not covered by UAB Student Health Services and will be my responsibility to pay (the UAB laboratory and X-ray departments may file my insurance but I will be responsible for any charges not covered by my insurance).
3. I agree to notify Student Health Services if there is a change in my insurance as stated below.
4. I understand that the insurance information provided below represents only myself.
5. By completing this waiver, I am confirming to have comparable insurance coverage for the academic year indicated on this form.

Major Medical Coverage Company	
Name of Insured	
Relationship to Students	
Policy Number	
Group Number	
Provider Services Phone Number	

_______________________________ Signature

_______________________________ Date Signed