

ATTENTION ALL STUDENTSST. JOHN'S UNIVERSITY
2006-07 INSURANCE INFORMATION/WAIVER FORM**(This form must be filled out completely)**

Students are required to have a health insurance policy in force while attending St. John's University. A student will automatically be enrolled in and billed for the Student Injury and Sickness Insurance Plan (SAS) unless the student carries comparable insurance, and submits this form by the deadline date.

Name of Student _____ Date of Birth _____
In case of emergency contact _____ at the following number:
Home phone _____ Work phone _____ Cell phone _____

You must check one of the four boxes below

1. I, as a student at St. John's University, attest that I/my parents have insurance coverage under a _____ current, in force insurance policy. This policy has a Major Medical Benefit of at least \$50,000, which is the minimum requirement.
2. I, as a **student-athlete** at St. John's University, attest that I/my parents have insurance coverage under a current, in force insurance policy. This policy has a Major Medical Benefit of at least \$75,000 and covers injuries that occur while participating in intercollegiate athletics, as required by the NCAA.
3. I, as a student at St. John's University, do not carry my own insurance, and wish to enroll in the SAS Basic Coverage Insurance plan offered by the college.
4. I, as a **student-athlete** at St. John's University, do not carry my own insurance and wish to enroll in the SAS insurance plan (Basic Coverage and Optional Sports Coverage) offered by the college. I understand there is a maximum benefit of \$75, 000 on the Optional Sports Coverage, required by the NCAA. I also understand the deductible is \$500, and I accept responsibility for out of pocket expenses.

(SAS enrollees must fill out and turn in an application to the St. John's Health Center)

If you have checked Box 1 or Box 2 fill in the information below.

Insurance Company Name _____
Insurance Company Address _____
Policy Holder Name _____
ID # _____ Group # _____
Effective Date of Policy _____ Expiration Date _____
Policy Limit _____ Policy Deductible _____ Co-Pay _____

I certify that the above information is true. If there is a change in coverage or expiration of coverage I agree to notify St. John's Health Center and update the insurance information I have on file. I understand and agree that St. John's University will assume no responsibility for the payment of, or authorization to pay, medical expenses including those that result in injuries that occur while participating in intercollegiate athletic at St. John's University.

Parent/Guardian Signature and Date

or

Student Signature and Date

Attach a copy of your current insurance card, front and back.
THIS FORM MUST BE COMPLETED AND RETURNED BY AUGUST 1, 2006.

Return to: St. John's Health Center
P.O. Box 7177
Collegeville, MN 56321
Keep a copy of this form for your records.