



**THE UNIVERSITY OF ALABAMA  
AT BIRMINGHAM  
STUDENT HEALTH SERVICES**

**Student Health Services  
930 South 20<sup>th</sup> Street South  
Suite 221  
Birmingham, AL 35294-2042**

**WAIVER OF UAB STUDENT HEALTH SERVICES INSURANCE PLAN**

**Blazer ID** \_\_\_\_\_ **Boo#** \_\_\_\_\_ **Social Security Number** \_\_\_\_\_

**Email** \_\_\_\_\_

<b>SEMESTER BEGINNING:</b> <input type="checkbox"/> Fall Semester <input type="checkbox"/> Spring Semester <input type="checkbox"/> Summer Semester <input type="checkbox"/> Other _____				
<b>LAST NAME</b>		<b>FIRST NAME</b>		<b>MIDDLE INITIAL</b>
<b>STREET ADDRESS</b>				
<b>CITY</b>		<b>STATE</b>		<b>ZIP CODE</b>
<b>TELEPHONE NUMBER:</b>	<b>SCHOOL OR COLLEGE IN WHICH YOU ARE ENROLLING (CHECK ONE):</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Optometry <input type="checkbox"/> Nursing <input type="checkbox"/> Health Professions <input type="checkbox"/> Public Health <input type="checkbox"/> Graduate (Degree Seeking) <input type="checkbox"/> International Student <input type="checkbox"/> International Scholar/Observer			

My signature below acknowledges...

1. I have major medical insurance coverage other than VIVA HEALTH student plan that meets the following minimum standards:
  - a) Physician and hospital coverage with providers in Alabama
  - b) Minimum of \$500,000 lifetime maximum benefit
  - c) Transplant Coverage
2. Procedures, labs, pap smears, X-rays, prescriptions and referrals ordered by Student Health Services providers are not covered by Student Health fee 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 have attached a copy of the front and back of the member identification card for the insurance referenced in item 1 above and agree to notify Student Health Services if there is a change in insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Major Medical Coverage Company Name

\_\_\_\_\_  
Policy #

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Relation to Student