THE UNIVERSITY OF ALABAMA
AT BIRMINGHAM
STUDENT HEALTH SERVICES

Student Health Services
930 South 20th Street South
Suite 221
Birmingham, AL 35294-2042

WAIVER OF UAB STUDENT HEALTH SERVICES INSURANCE PLAN

Blazer ID _____ **Boo#** _____ **Social Security Number** _____

Email _____

SEMESTER BEGINNING: ☐ Fall Semester ☐ Spring Semester ☐ Summer Semester ☐ Other _____		
LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
STREET ADDRESS		
CITY	**STATE**	**ZIP CODE**
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. 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