MILES COLLEGE HEALTH INSURANCE WAIVER FORM

Student Number:	**Telephone #:**	**e-mail address:**
Last Name:	**First Name:**	**Middle Initial:**
Street Address:		
City:	**State:**	**Zip Code:**
Semester Beginning: € Fall Semester € Spring Semester Academic Year _____		
Insurance Subscriber: (person to whom policy is issued)_____		
Insurance Company:_____ **Policy Coverage Effective Dates:**_____ **Policy/Group Number**_____		
By signing this Waiver of Insurance, I certify that I am currently participating in a health insurance plan other than the one offered by the college. _____ _____ **Student's Signature** **Date**		