ASSOCIATED INSURANCE PLANS
INTERNATIONAL, INC.

Student Health Insurance Waiver Form

Section I

Personal Information

College or University: _____

Student Name: _____ ___Male ___Female

Address: _____ City: _____

State: _____ Zip code: _____ Phone #:_____

Email: _____ UIN (ID#): _____

Date of Birth: _____ Social Security #: _____-_____-_____

Section II (REQUIRED)

Insurance Company Information

Insurance Company: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Individual Policy __ Group Policy (if so, which group? _____

Policy #: _____ Group #: _____

My coverage begins on: ___ /____ /_____ My Coverage ends on: ___ /___ /_____

Primary Insured's Name (if other than self):_____

Primary Insured's Date of Birth: _____

*If this insurance does not meet the requirements of your College/University, please contact AIP International, Inc. at 800-452-5772, or email us at office@aipinternational.com .

Section III

Waiver Information

By signing and placing a mark (√, X) next to the items below, I am stating that I understand this document. I have read it in its entirety. Also, I am legally responsible for all medical expenses incurred while attending the above College/University. The College/ University will not be responsible for any medical expenses incurred while enrolled/attending the school.

__ I have health insurance with another carrier and I have provided my Insurance Company's information in Section II. I do not want to be a member of the Insurance Plan offered by my College/University. I would like to waive out of this coverage.

Signature: _____ Date: _____ / _____ / _____

Name: _____ (please print)