



Florida Gulf Coast University
 Student Health Services
 10501 FGCU Blvd. South
 Fort Myers, FL 33965
 (239) 590-7966
 (239) 590-7474 fax

Insurance Hard Waiver Form 2007-2008
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Students in the College of Health Professions must show acceptable proof of health insurance. This form should be submitted in person to the College of Health Professions or faxed to the above number. The deadline to submit a waiver is September 15, 2007

	YES	NO
1. Does your plan have a provider in the Fort Myers/Naples (Lee/Collier) area? Coverage must be available for urgent care and physician visits as well as emergency and local hospital care. (Some HMO's may pay for away from home care but require that a student go to a primary physician first which could be in another city or they may only pay for emergency care in Fort Myers/Naples - that is not sufficient.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your plan offer a minimum of \$250,000 in benefits yearly?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your plan offer Prescription Drug Coverage?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your plan provide inpatient and outpatient mental health benefits?	<input type="checkbox"/>	<input type="checkbox"/>
5. Will coverage for your student be valid for the entire academic year: August 20, 2007 through August 17, 2008?	<input type="checkbox"/>	<input type="checkbox"/>
6. For female students, does your plan cover pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your plan have a deductible of no more than \$500/year?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are preexisting conditions covered?	<input type="checkbox"/>	<input type="checkbox"/>

Student Name: _____

Social Security #: _____

Insurance Information

Insurance Company Name: _____

Insurance Company Mailing Address: _____

Insurance Company Telephone #: _____

Policy Holder Name (full name): _____

Relationship to student (please circle): self parent spouse

Policy Number: _____ Group Number: _____

Effective date of policy: _____

Termination date of policy: _____

Parent/Guardian Name: _____

Parent/Guardian contact telephone or e-mail: _____