Ocean County College
Student Insurance Waiver Card 2009-2010

(PLEASE PRINT)

Student's Name____Soc. Sec. #____________________________
Last First Middle Initial

Student's Home Address____
Street or PO Box City State Zip

I will not be joining the Student Health Insurance Plan for the current academic year because I have coverage comparable to the health benefits of the College Plan through my own or my family's membership in the following group or private policy:

Name of Insured____Relation to Student__________________

Name of Insurance Company or Group____

Address of Company____
Street or PO Box City State Zip

Policy or Group #____Date of Expiration____________________________

I hereby certify that to the best of my knowledge the information I have supplied is true and accurate. I also fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the College.

Date____________________ Signature X____

Note: This waiver will not be valid, if received after 9/30/09 for the Fall semester, or 2/28/10 for the Spring semester. Additionally, you may wish to retain this coverage even if you have coverage elsewhere, as the benefits paid by this plan may reduce or eliminate any out of pocket costs associated with your other coverage.