



Cornell University  
Office of Student  
Health Insurance

Student Health Insurance Plan  
Enrollment/Waiver Form  
**SUMMER DAIRY INSTITUTE PROGRAM, 2009**

**INSTRUCTIONS:** Please fill out either the ENROLLMENT or WAIVER section of this form and return **no later than May 1, 2009** to:

**Cornell Dairy Institute**  
S2005 Schurman Hall  
Ithaca, NY 14853

Questions about insurance?  
Phone: 607.255.6363  
E-mail: sicu@cornell.edu

(Due to policy restrictions, students may not enroll in or cancel the SHIP after the program begins.)

Name \_\_\_\_\_ Date of Birth     /    /     Gender  Female  Male  
*(Last, First - Please print clearly using ink)* *(mm/dd/yy)*

E-mail Address \_\_\_\_\_ Cornell 7-digit Student I.D. # \_\_\_\_\_

Local Address \_\_\_\_\_

**ENROLLMENT**

Enroll me in the Student Health Insurance Plan. I will send the \$252.33 payment for the premium (US Currency payable to Cornell University) no later than May 1, 2009 to the address above. Coverage dates are 6/1/09 to 7/24/09. I also understand that **this policy is nonrefundable** if I leave the Summer Dairy Institute Program early for any reason.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**WAIVER**

I have health insurance that satisfies the conditions listed below, and I do not wish to purchase the Student Health Insurance Plan.

- You must indicate that your plan meets each of the conditions below by checking the "yes" boxes.
- If your coverage does not meet all six of these conditions, you may not waive. You must purchase the Student Health Insurance Plan.
- If you do not know whether your coverage meets these conditions, contact your health insurance plan administrator to get current, accurate information about your plan before completing this form.

**YES NO**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. My plan is provided by a company licensed to do business in the United States, with a US claim payment office and US phone number.                                |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. My plan provides coverage in the Ithaca area for outpatient and inpatient medical care. (Coverage for emergency care only does <i>not</i> meet this requirement.) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. My plan provides coverage in the Ithaca area for outpatient and inpatient mental health care.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. The maximum benefit for my coverage is at least \$500,000 per year.   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. My coverage will remain in force as long as I am a full-time registered student (including in absentia and non-degree status) at Cornell University.              |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. My plan provides coverage for pre-existing conditions.  |

Insurance Company: \_\_\_\_\_ (incl. Medicaid/Medicare)

Subscriber Name: \_\_\_\_\_ Subscriber Birthdate:     /    /    

Subscriber's Relationship to Student: \_\_\_\_\_ Insurance Policy #: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ Insurance Co. Phone #: \_\_\_\_\_

**NOTE:** Cornell University reserves the right to verify insurance information. If your plan does not meet these requirements, or you are uninsured, you will automatically be charged for and enrolled in the Student Health Insurance Plan.

**WAIVER PETITION SIGNATURE**

By my signature, I affirm that I have health insurance coverage that meets *all six* of the conditions described above. I understand I am legally responsible for all medical expenses incurred during my enrollment at Cornell University and that the University will not be responsible for any medical expenses.

Signature \_\_\_\_\_ Date \_\_\_\_\_