OSGOODE

OSGOODE HALL LAW SCHOOL

Student Benefits Waiver Form

This waiver form is to be used by students who have been enrolled in their student organization's health and/or dental plan(s) administered by Gallivan & Associates Student Networks (G&A), but wish to waive the coverage for such plan(s) because he/she currently has comparable coverage elsewhere. ***Please complete this form and submit it along with confirmation of existing coverage*** to the Benefits Plan Office. The waiver form along with confirmation of coverage specific to health and/or dental must be received by the **DEADLINE DATE ESTABLISHED BY THE STUDENT ORGANIZATION. NO EXCEPTIONS ARE MADE.**

PLEASE NOTE: If you lose the comparable coverage used to waive the health and/or dental plan(s), you must notify the Health Plan Administrator within **30 days** to be covered by the Student Benefits Plan.

INCOMPLETE WAIVER FORMS INCLUDING THOSE SUBMITTED OR FAXED WITHOUT CONFIRMATION OF EXISTING COVERAGE WILL NOT BE PROCESSED.

Confirmation of existing coverage must show the name of the insurance company providing coverage and the policy number. The easiest way for you to provide confirmation of coverage is by presenting a copy of a benefits card or a confirmation letter from the employer/insurance company. Confirmation may also be provided by presenting other documents such as a recent statement of claim, web page print-out or other insurance company document identifying you, the insurer and the policy number.
Once we confirm coverage, we DO NOT retain any confirmation documentation that you provide to us.

STUDENT INFORMATION

Last Name _____ First Name _____ Initial _____ Gender _____ Birth Date (DD/MM/YY) D D M M Y Y

Mailing Address _____ City/Province _____ Postal Code _____

Program Name _____ Program Start Date (DD/MM/YY) D D M M Y Y Student ID Number _____

EXISTING COVERAGE INFORMATION

I have existing extended health coverage and wish to use that coverage to waive the Student Extended Health Plan coverage.

☐ Yes ☐ No Insurer's Name _____ Policy No. _____

I have existing dental coverage and wish to use that coverage to waive the Student Dental Plan coverage.

☐ Yes ☐ No Insurer's Name _____ Policy No. _____

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:
I wish to decline the student health and/or dental plan(s) coverage. Comparable health and/or dental coverage is presently provided for me under another insurance plan in addition to my provincial health care. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the student health and/or dental plan(s). I realize that I will not be able to rejoin the plan(s) until I enrol next year or unless I cease to be covered by my existing plan and apply within **30 days**. I **MUST** contact the Health Plan Administrator to reinstate coverage. I understand that I would have been able to claim under my existing insurance as well as under the student health and/or dental plan(s), thereby increasing my coverage.

I understand that the information provided above is required in order for me to waive the extended health and/or dental coverage. I hereby authorize and consent to the use, release and exchange of the above information between the educational institution, the student organization, Gallivan & Associates, third party service providers and the insurance carrier(s) to be used solely in connection with the administration of the Student Benefits Plan. I confirm that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Health Plan Administrator has received and approved my waiver application.

X _____ ( ) - Date (DD/MM/YY) D D M M Y Y

Student Signature Phone

YOU MUST SUBMIT THIS WAIVER PRIOR TO 4:00 p.m. ON THE ASSIGNED DEADLINE DATE

Waiver forms will not be returned. After it has been signed by the Health Plan Administrator, please make a copy for your records prior to submitting. If you fax in the waiver form, it is the student's responsibility to retain a copy of the fax transmission report.

OFFICE USE ONLY D D M M Y Y Processing Date (DD/MM/YY) _____ Processed By

GALLIVAN & ASSOCIATES STUDENT NETWORKS

The Integrated Care Solution