

Request for Hospital Insurance Wavier

Use this form to request your hospital insurance premium be removed from your bill...

I wish to waive hospital insurance coverage through SUNY Plattsburgh. I certify I am covered by another hospital insurance policy that will be in effect for this semester. I am personally responsible for payment of all medical expenses incurred by me or required by SUNY Plattsburgh.

Today's Date *(mm/dd/yy)* _____

Name *(please print)* _____

Signature _____

Banner ID or SSN _____ Policy # _____

Company _____



All waiver requests must be filed within 30 days of the first day of classes each semester.