GRADUATE STUDENTS' UNION
MEMORIAL UNIVERSITY OF NEWFOUNDLAND

OPT-OUT FORM
SUPPLEMENTARY HEALTH/DENTAL INSURANCE

Opt-Out Form, for students with existing spousal, parental or other Health and/or Dental insurance coverage:

I am a full-time registered graduate student. I wish to decline the student supplemental Health and/or Dental Plan(s) coverage available through the Memorial University of Newfoundland Graduate Students' Union (GSU). **Comparable coverage** is currently provided for me under another plan in addition to my provincial health insurance plan. I acknowledge that as a result of this waiver:

1. I forfeit all right of coverage otherwise available to me under the GSU Health and/or Dental Plan(s).
2. I will only be able to rejoin this plan(s) if my existing coverage ends.
3. I am not able to claim under both insurance policies and, thereby, increase my coverage above the total of the expense.
4. I will not need to Opt Out again for the remainder of my program ***UNLESS*** there is a change in my student status. It is my responsibility to advise the GSU of any status change, either by phone, fax, email or in person.
*** Documentation of existing coverage must clearly show ***your name***, ***the name of the Insurance Company*** providing the coverage, ***the policy number*** *and* ***main benefits*** *(i.e. health, dental, drug, etc).* Acceptable documentation is a certificate from the insurance company, a copy of your insurance policy or the membership card of your current plan. You must return this completed form and documentation (i.e. proof of existing coverage) by **January 26, 2012** to the Graduate Students' Union in person, by fax or email **in order to be opted out of the plan(s) starting in the Winter 2012 semester**. ***

Graduate Students' Union, GH-2007, Feild Hall, 216 Prince Philip Dr., St. John's, NL, A1B 3R5
Ph: (709) 864-4395 Fax: (709) 864-3395 Email: health@gsumun.ca or gsu@gsumun.ca

PRINT CLEARLY

Student Name: _____
(Last Name) (First Name)

Student Number: _____ Date of Birth (mm/dd/yyyy): _____

Email: _____Phone Number: _____

Home Address: _____

I want to:	**OPT OUT**	**KEEP**	if opting out, provide Insurance Company and policy number: (**Attach necessary documentation, see above**)
Health (Please check one)	☐	☐	_____
Dental (Please check one)	☐	☐	_____

STUDENT (SIGNATURE): _____ DATE: _____

AUTHORIZATION: _____ DATE: _____