

WAIVER CARD

STUDENT HEALTH INSURANCE

CUMBERLAND COUNTY COLLEGE

(PLEASE PRINT)

Student's Name _____ ID # _____
Last First Middle Initial

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 _____ Policy or Group # _____

Address of Company _____

I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the College.

Date _____ Signature X _____

Please return to one of the below:

bursar@cccnj.edu • Fax 856-691-6483 • Mailing Address: PO Box 1500 • Vineland, NJ 08362