*INSURANCE ENROLLMENT SHEET: 200_-200_*

You may email your decision and information to cevans1@swarthmore.edu or fax: (610) 328-8487

Print Student Name:_____ Class Year _____

___ **Option (1)**: My insurance, as listed below, meets the College requirements. I have enclosed a photocopy of the cards. I wish to WAIVE the Swarthmore College Plan.

Signature: _____ Parent (if less than 18 y.o.)_____

PRIMARY INSURANCE COMPANY: Mandatory if not enrolling in the Swarthmore College Plan

Company Name _____

Policy Holder & Identification #_____

Group Name or Number _____

Address _____

_____

Telephone Number _____Does your insurance require precertification? __ yes __ no

SECONDARY INSURANCE COMPANY:

Company Name _____

Policy Holder & Identification #_____

Group Name or Number _____

Address _____

_____

Telephone Number _____Does your insurance require precertification? __ yes __ no

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____ **Option (2)**: I would like to enroll in the College Health Insurance Plan @ the current rate for the year beginning August 17, 200_. and ending one year later August 17, 200_.

____ Because of economic hardship, I would like to be considered for a discounted rate. I do not have other health insurance that meets the minimum requirements as set forth by the College.

Signature: _____ Parent (if less than 18 y.o.)_____