

**FRANKLIN W. OLIN COLLEGE OF ENGINEERING
STUDENT HEALTH INSURANCE PLAN**

2011-12 ENROLLMENT/WAIVER FORM

ALL STUDENTS MUST COMPLETE THIS FORM

Massachusetts law requires that all students enroll in the Aetna Student Health Insurance Plan offered through Olin College **OR** demonstrate that they have comparable coverage in another plan. A new Enrollment/Waiver Form must be submitted each academic year. This form must be returned to Loretta Dinon, Manager of Student Accounts, by June 30, 2011.

If this form is not completed, signed and returned by the specified date, YOU WILL IRREVOCABLY BE ENROLLED IN AND BILLED FOR THE STUDENT HEALTH INSURANCE PLAN OFFERED THROUGH OLIN COLLEGE, as required by Massachusetts law.

Student Name: _____ SSN#: _____ Date of Birth: _____

Home Address: _____
Street City State Country Zip Code

PLEASE CHECK THE APPROPRIATE BOX:

YES:

**ENROLL ME IN THE AETNA STUDENT HEALTH INSURANCE PLAN OFFERED THROUGH OLIN COLLEGE. POLICY NUMBER 812803
PLAN EFFECTIVE DATES: AUGUST 18, 2011 THROUGH AUGUST 17, 2012**

By my signature, I hereby request enrollment in the Aetna Student Health Insurance Plan and understand that the \$916 premium will be charged to my student account statement.

Student Signature: _____ Date: _____
(Parent or Guardian if Student is under 18 years of age.)

NO: I do not choose to enroll in the Student Health Insurance Plan offered through **Olin College**
I certify that I have comparable coverage as indicated below.

The following categories are not eligible for a waiver:

- Coverage from insurance carriers outside the US and/or coverage from National Health Services programs
- Students determined to be Low Income Patients for Services Eligible under Uncompensated Care Pools
- Students whose health plan does not provide reasonably accessible services in the Olin area for non-emergency care

Name of Insurance Carrier: _____ Policy Number: _____

Policyholder's Name: _____ Relationship to Student: _____

I have compared my health insurance coverage to the Student Health Insurance Plan offered through Olin College. I have comparable coverage that will be valid for the entire academic year and therefore choose to waive this Plan. By submitting this signed waiver I acknowledge full responsibility for any medical expenses incurred during my enrollment at Olin College.

Student Signature: _____ Date: _____
(Parent or Guardian if Student is under 18 years of age.)

RETURN COMPLETED FORM BY JUNE 30, 2011 TO: Loretta Dinon
Manager of Student Accounts
Franklin W. Olin College of Engineering
Olin Way
Needham, MA 02492-1200

For information on Olin's Student Health Insurance Plan, please go to
www.aetnastudenthealth.com and click on the Student Connection