Southern Wesleyan University
Health Center
Insurance Requirement Waiver Request Form

Name: _____Date: _____
Student ID #: _____
Date of birth: _____
Phone #/email address: _____

I, _____request to be waived from
(please print student's name)
Southern Wesleyan University's requirement for medical insurance. The reason I am requesting this waiver is_____
_____
_____
_____
_____
_____
_____

How will you pay for routine medical care? (colds, coughs, etc) _____
_____

How will you pay for urgent medical care? _____
_____

_____
Student's Signature

OFFICE USE ONLY:
Waiver approved
Waiver not approved
Notes/Additional information _____
_____
_____
_____

_____
Signature – Vice President for Student Life