WESTERN
ILLINOIS
UNIVERSITY

Student Name ______________________________

Student ID #______________________________

STUDENT HEALTH INSURANCE REINSTATEMENT FORM

I request Western Illinois University to cancel my insurance waiver. I understand that cancellation of the waiver will allow me to be listed as an insured student at Western Illinois University for all following terms if I meet the eligibility requirements listed below for undergraduate or graduate students:

- I must be enrolled in nine semester hours or more of on-campus classes (excluding post-session, extension, correspondence, or extramural hours).
- If I am a graduate assistant under contract to the university, enrolled in a minimum of one semester hour, I am automatically charged the insurance fee.
- WESL students are all automatically assessed the insurance fee.

In order to have the insurance fee/coverage reinstated at any time other than the enrollment period at the beginning of the fall or spring term, we must have verification that your primary insurance company has cancelled your coverage with them. Cancellation of your primary insurance may be as a result of a student's age, loss of a job, switching insurance carriers—just to name a few examples. If your primary insurance does cancel your coverage, you must complete this form and return it to our office with verification that your coverage was cancelled. You have 30 (thirty) days from the date your primary insurance cancelled to reinstate WIU's student health insurance.

I understand that cancellation of my insurance waiver does not automatically guarantee that I will remain insured for subsequent semesters. I understand that it is my responsibility to follow university guidelines for enrollment in the student health insurance plan. For additional information, please refer to the student health insurance brochure or contact the office at 309/298-1882.

______________________________ Student Signature

______________________________ Date

Mark the term you wish insurance to begin:

FALL 20______ __________

SPRING 20______ __________

Return to:
Student Health Insurance
Lower Level/Beu Health Center
Western Illinois University
Macomb, IL 61455

PLEASE COMPLETE THE FOLLOWING ADDRESS FOR CONFIRMATION TO BE SENT:

NAME ______________________________

ADDRESS ______________________________

CITY ____________________ STATE/ZIP ____________

For office use only:

APPROVED____ REJECTED____

initial__________ date__________