Section 1 - Student Information

Full Name: 
Date of Birth: / / 
Student ID: 
Phone #: 
Email: 

Section 2 - Original Transaction

Confirmation #: 
Submitted: / / 
Select One:
- I initially elected to waive but want to enroll. Please cancel my original transaction.
- I initially elected to enroll but now want to waive. Please cancel my original transaction. My waiver information is as follows in Section 3.

Section 3 - Waiver Information (if electing to enroll, skip this section)

Name of Insurer: 
Insurer Phone: 
Policyholder Name: 
Policy #: 
Relation to policyholder (circle one) | Self | Dependent Spouse | Dependent Child

I attest that my alternative coverage provides similar coverage to the university-sponsored plan and:
• The Claims administrator is based in the United States and has a US telephone number and address for submission of claims
• The plan provides both emergency and non-emergency health care and mental health benefits in the Durham, NC area
• Out of state Medicaid and state Children’s Health Insurance Plans do not cover non-emergency care in Durham
• The plan has participating hospitals, physicians, pharmacies, and mental health providers in the Durham, NC area to include Duke Medicine
• The plan provides inpatient and outpatient mental health care (with at least 30 visits per year) and chemical dependency benefits are comparable to the coverage provided by the Duke SMIP
• The plan provides coverage for prescription medication
• The lifetime benefit is at least $500,000 or more

Section 4 - Certification

Signature: 
Date: 
Email: Kelan.Beacham@duke.edu 
Fax: 919-681-2874
Mail: DUMC Box 2899, Durham, NC 27710

Change requests must be submitted by 5PM January 31, 2015 to be valid.