



**HEALTH INSURANCE PLAN
WAIVER**

I, the undersigned **name** _____ **I.D. No.** _____,
hereby declare that I have been informed about the Health Insurance Plan and that its
regulations have been explained to me.

I also hereby request exemption from enrolling in the Health Insurance Plan. Further,
I fully understand that I will be responsible for payment in full of all expenses incurred
at the American University Medical Center or any other medical care provider.

FOR OFFICE USE ONLY
Witness: _____

Signature: _____

Position: _____

Date: _____