

AMERICAN UNIVERSITY OF BEIRUT
HUMAN RESOURCES DEPARTMENT - CAMPUS
Benefits Coordinator's Office

HEALTH INSURANCE PLAN WAIVER - STUDENT-
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I, the undersigned (**Name**) _____ **St. Id** _____,
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 medical care
expenses incurred at the American University Hospital or any other health care
provider.

FOR OFFICE USE ONLY
Witness: _____

Signature: _____

Phone/Email/POBox: _____

Faculty: _____

Date: _____

- Notes:** 1. Copy of the health insurance policy is required with this waiver form.
2. Copy of the renewal of the health insurance policy is required if it
expires during academic year 2008-2009.