

Your Return Address

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLACE  
PROPER  
POSTAGE  
HERE

ST. JOHN'S COLLEGE  
ATTN: HEALTH CENTER  
P.O. BOX 2800  
ANNAPOLIS, MD 21404-2800

INSURANCE WAIVER

**You are automatically charged for insurance. You will not receive a credit for insurance unless your waiver card is received by the business office NO LATER THAN August 1, 2011.**

Student's Full Name:

\_\_\_\_\_  
Last

\_\_\_\_\_  
First

\_\_\_\_\_  
Middle

I will not be joining the St. John's College sponsored Health Insurance Plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at St. John's College and that St. John's College will not be responsible for any medical expenses. I am currently covered under the following policy:

\_\_\_\_\_  
Insurance Company Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Insurance Company Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Signature (student)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature (Guardian)

\_\_\_\_\_  
Date

Mail card to:

St. John's College  
Attn: Health Center  
P.O. Box 2800  
Annapolis, Maryland 21404-2800

or Fax Card to: 410-626-2889