



**WILLIAM  
& MARY**  
CHARTERED 1693

## Student Health Center

240 Gooch Drive, Williamsburg, VA 23185  
Phone: (757) 221-4386 / Fax: (757) 221-1245  
E-mail: [sthlt@wm.edu](mailto:sthlt@wm.edu)

### Notice of Change of Insurance

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  W&M  VIMS  
WM Email: \_\_\_\_\_ Phone: \_\_\_\_\_

I furnished proof of other adequate health insurance coverage by submitting an approved waiver request for the \_\_\_\_\_ academic year but my current health insurance has changed. So I hereby notify the College of William & Mary Student Health Center (SHC) of this change of insurance. My health insurance coverage changed for the following reason: *(please check one)*

- |   |   |
|---|---|
| <input type="checkbox"/> Death                | <input type="checkbox"/> Divorce, Separation or Annulment |
| <input type="checkbox"/> Change in Employment | <input type="checkbox"/> Change in Insurance Plans        |
| <input type="checkbox"/> Marriage             | <input type="checkbox"/> Birth/Adoption                   |

This change will be/was effective: \_\_\_\_\_

*Please check the appropriate response below:*

I have the following other adequate health insurance coverage\* and this coverage is effective for the remainder of the academic year, therefore I **DON'T WISH** to be enrolled in the W&M-sponsored Student Insurance Plan.

Insurance Company Name: \_\_\_\_\_  
Insurance Company Phone: \_\_\_\_\_  
Policy Holder (PH) Name: \_\_\_\_\_ PH Date of Birth: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

I do not have other adequate health insurance coverage, therefore I **WISH** to be enrolled in the W&M-sponsored Student Insurance Plan.

Students must be registered as a full-time student and must be actively attending classes for at least the first 31 days after the date for which coverage is purchased to be eligible for the plan. The student will be billed the full premium for the current coverage period, the premium may not be prorated. If you have any questions as to whether or not you are eligible to enroll in the Student Insurance Plan, please contact the Student Insurance Coordinator at (757) 221-2978 or [student.insurance@wm.edu](mailto:student.insurance@wm.edu).

#### Acknowledgement:

By signing, the student acknowledges that following: 1) He/She is aware of the College's Insurance Requirement and in accordance with this requirement, the student is notifying the College in a timely manner of any change in health insurance coverage so that the appropriate action can be taken to ensure the student remain compliant with the College's requirement; 2) If the student has other adequate health insurance coverage, that other insurance is effective for the entire academic period; 3) If the student is requesting to be enrolled in the student insurance, enrollment is guaranteed (as long as there are at least 31 days of class remaining) with the coverage effective on the date of notice or date of termination of other insurance, whichever is later; 4) That the information provided herein is true and correct to the best of his/her knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*If possible, please attach a copy of the front and back of your new health insurance card for inclusion in your medical record.