



Hospitalization Insurance Waiver

Limited time to submit: By October 15th for Fall Semester
By February 15th for Spring Semester

Print Student Name

Student ID

I elect not to join the MCCC Insurance Plan because I have coverage comparable to the hospitalization benefits of the college policy through a membership in the following policy:

Term & Year: _____

Name of insurance company: _____

Date: _____ Signed: _____
Student (Parent or Guardian if the student is not 18 years old)

This form must be signed and returned to the Office of Student Records. Failure to return the form will result in automatic billing for the MCCC Hospital Insurance Plan. Note: This form must be filled out EVERY semester.