studentVIP

Application to Opt-Out of Student Health Coverage

UWSA University of Windsor Students' Alliance

Student Information

Student I.D.# _____

Student's Name: _____ **Date of Birth:** _____ (Year / Mo. / Day)

Student's Brock E-mail Address: _____ **Telephone #** ( )

Student's Address while at university: _____
No./Street | Apt./Unit# | City/Town | Prov. | Postal Code

Student's Permanent Home Province: ☐ **Same as Above** **Or** ☐ **Other:** _____

Enrolled In: ☐ **Fall Term (September)** **International Student?** ☐ **Yes** ☐ **No**

Request to Opt-Out of Coverage

Deadline: September 30, 2025 at midnight

To be eligible to Opt-Out, you **must** be covered by comparable coverage.

I hereby request to Opt-Out of:

☐ Extended Health Coverage* ☐ Dental Coverage

*Note: When you opt-out of the Extended Health Coverage, the Out of Canada/Province (OOC)/Travel Assist insurance coverage is automatically terminated along with the Extended Health Coverage

Certification & Proof of alternative coverage required:

☐ Attach copies of any documents indicating the name of the primary insured person (i.e. your parent or spouse/common-law partner) and insurance certificate/card(s), verifying that you are insured under comparable coverage, and the name of the other insurer. Complete below:

	Name of Insurer Providing Comparable Coverage	Policy/Certificate #	Insured Person's Name & Relationship to You (i.e. your parent, spouse)
Extended Health			
Dental			

☐ If applicable, attach a photocopy of your Indian Status Card or Government Assistance Health Plan Card.

Student's Certification & Authorization

- I certify that I have comparable coverage.
- I understand that in order to be refunded any premiums paid, this completed form and any related documents requested must be received by the UWSA Health Plan Office by the deadline of September 30, 2025. No exceptions or extensions.
- Having read the Student Health Plan brochure, I understand and agree that UWSA has provided me with all the information which I deem necessary for making an informed and responsible decision regarding my health coverage.
- I understand that each benefit year, a new opt-out application form must be filled out prior to that year's deadline.
- I understand that the coverage which I am declining may not be similar to the alternate coverage that I am insured under at this time.
- I understand that by opting out of the above coverage, I may be losing the advantage of being covered by my student health plan and my comparable coverage, to possibly increase my total benefits by claiming Coordination of Benefits (COB) between the plans.
- I understand that once I have opted out of the coverage under the Student Health Plan as indicated above, I am not eligible under any circumstance to opt back into the plan before September 1st, 2026.

I declare that the statements made on this form are complete and true. I understand the information I provide on this form and any related documents provided on request, will be used by the University of Windsor Students' Alliance (UWSA) via their Student Health Plan Office and the student financial services office of the university for the purposes of administering my student health plan. Any true copy of this authorization shall be considered as valid as the original.

Student's Signature: _____ **Date** _____

Submit To: UWSA Student Health Plan Office, CAW Student Centre, Room #209
Phone: 519-253-3000 Ext# 3600 www.studentvip.ca/uwsa

BUSU Health Plan Office Use Only

Date Application Received: _____ (Year / Mo. / Day) **Initials of Receiver:** _____

Complete Opt-Out: ☐ **Yes** ☐ **No** ☐ **Accepted** ☐ **Declined** **Reason if Declined:**