studentVIP

Application to Opt-Out of Student Health & Dental Coverage

ASU Acadia Students' Union

Student Information (Please print clearly)

Student I.D.# _____

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

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

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

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

Enrolled In: ☐ **Fall Term (September)**

Request to Opt-Out of Coverage

Deadline: September 30, 2025

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

☐ I hereby request to opt-out of Extended Health* and Dental 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)

☐ If applicable, attach a photocopy of your First Nations 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 ASU Supports Office by the deadline of September 30, 2025 at 11:59pm. **No exceptions or extensions.**
- Having read the Student Health Benefits brochure, I understand and agree that ASU 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 benefits 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 Benefits as indicated above, I am not eligible under any circumstance to opt back into the benefits 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 Acadia Students' Union (ASU) via their Student Health Plan Office and the student financial services office of the college for the purposes of administering my student health benefits. Any true copy of this authorization shall be considered as valid as the original.

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

Application MUST be accompanied by supporting documentation

Submit to:
ASU Supports Office
Phone: 902-585-2167
info@ASUsupports.ca

Acadia Health Plan Office Use Only

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

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

Reason if Declined: