Application to Opt-Out of Student Health Coverage

Student Information

Student I.D.# _____

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

Student's Personal 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 19, 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, both the Out of Canada/Province (OOC)/Travel Assist benefit and the Student Accident Insurance coverages are 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)

☐ 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 Students' Union Health Plan Office by the deadline of September 19, 2025 at midnight (Fall) or January 16, 2026 at midnight (Winter.) **NO EXCEPTIONS OR EXTENSIONS**;
- Having read the Student Health Benefits brochure, I understand and agree that Students' Union 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 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 circumstances to opt back into the benefits before September 1, 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 Wilfrid Laurier University Student Union (Students' Union) via this Student Health Plan Office and the student financial services office of the university for the purposes of administering my student health benefits. Any true copy of this authorization shall be considered as valid as the original copy.

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

OPT-OUT SUBMISSION

Submit via E-mail: undergradhdp@wlu.ca **Health Plan:** 519-884-0710 ext. 3557

WLU Health Plan Office Use Only

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

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

☐ **Accepted** ☐ **Declined**

Wilfrid Laurier University and the Wilfrid Laurier University Students' Union are committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.