BELCROFT UNIVERSITY
Waters Edge Office Center, 2963 Gulf To Bay Blvd, Suite# 120, Clearwater, FL - 33759
admissions@belcroftuniversity.com
+1 (813) 772-3772

Health Insurance Waiver Request Form

Purpose

Belcroft University requires all enrolled students to maintain adequate health insurance coverage throughout their enrollment period. Students who already possess comparable coverage through an employer, government plan, private provider, spouse, parent, or another qualified source may request a waiver from the University's Student Health Insurance Plan.

However, submitting a waiver request does not guarantee approval. The University reserves the right to review all policies to determine whether the alternative coverage satisfies University requirements.

Student Information

Student Name (First - Middle - Last)	
Student ID Number	
Student Email	
Phone Number	
Semester Applying For	☐Fall ☐Spring ☐Summer
Current Address	
Country of Citizenship	
Date of Birth	_____ /_____ /_____

Health Insurance Information

Insurance Company Name	
Policy Number	
Policy Effective Date	
Policy Expiration Date	
Insurance Company Phone Number	
Insurance Company Website	

Requiring Supporting Documents

- Copy of Insurance Card (Front)
- Copy of Insurance Card (Back)
- Insurance Policy Summary
- Benefits Coverage Document
- Verification of Active Coverage
- Additional Documentation (if requested)

BELCROFT UNIVERSITY

Waters Edge Office Center, 2963 Gulf To Bay Blvd, Suite# 120, Clearwater, FL - 33759

admissions@belcroftuniversity.com

+1 (813) 772-3772

Student Acknowledgement

☐ I certify that the information provided on this form is true and complete. I understand that Belcroft University may request additional documentation to verify my eligibility for a health insurance waiver.

Student Signature: _____ **Date:** ____ / ____ / _____

University Review

Insurance Card Received	☐ Yes ☐ No
Policy Documentation Received	☐ Yes ☐ No
Coverage Verified	☐ Yes ☐ No
Meets University Requirements	☐ Yes ☐ No
Waiver Decision	☐ Approved ☐ Denied

Reason for Denial (if applicable):

_____

_____

University Authorization

Name	
Title	
Department	
Signature	
Date	/ /

For Office Use Only

Date Received	/ /
Date Reviewed	/ /
Date Approved/Denied	/ /