Icahn School of Medicine at **Mount Sinai**

Office of the Enrollment and Student Services

One Gustave L. Levy Place
Annenberg Building-Rm 12-70
Box 1002
New York, NY 10029-6574

Phone 212.241.5245
Facsimile 212.876.4658

Insurance Billing Record/Waiver Form
For INCOMING Students - 2014-2015
Medical/Dental/Vision Coverage

Please select the program in which you are enrolled in:

☐ MD ☐PhD ☐ MD/PhD

☐ PREP ☐ PHD/CLR ☐ MSBS

☐ MSCR ☐ MPH ☐ MGC

This form is for Financial Services records only.

Life #: _________________ Class of: _________

Last Name: ____________________ First Name: ________________ MI: ____
SS#: __________________ Sex M___ F___ Date of Birth: __________

LOCAL Address: ____
City _________________ State _____ Zip ___________ Phone # ________________

New Coverage : _____
Request for Change: _____
WAIVE COVERAGE: _____ **(You must attach a copy of your insurance card to waive coverage.)**
You must be insured. By waiving, your coverage will continue to be waived until you request coverage through Mount Sinai.

(Leave Blank if WAIVE COVERAGE)

Coverage requested: Basic Medical, Coverage is thru June 30th.
Single: ___________
Single + 1: ________
Family: ___________

OPTIONAL Coverage requested:
Dental, Coverage is thru June 30th.
Student: __________
Single + 1 ________
Family ___________

Vision, Coverage is thru June 30th:
Single: ___________
Single + 1: ________
Family: ___________

I understand that this form is used by Student Financial Services for billing purposes only and that I will be responsible for all the charges checked above. Charges will be listed on tuition invoice, sent by Bursar, via email. Payment is due upon receipt. Unpaid charges will be turned over to a collections agency.

Signature: ____ Date: _________________