CASE WESTERN RESERVE UNIVERSITY**UNIVERSITY HEALTH SERVICE
10900 EUCLID AVE**CLEVELAND OH 44106-4901**(216) 368-2450

CHANGE IN INSURANCE COVERAGE STATUS FORM

Name: _____ School:_____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____ Student ID _____

Male: _____ Female:_____ Case Network ID _____

I am submitting a letter from my insurance carrier (or employer offering health coverage) which states I am no longer covered under their medical policy. I, therefore, need to apply for the Case Western Reserve University Student Medical Plan coverage for the remainder of fall semester 2023.

I understand I must pay $_____ for this coverage at the time of this application. I also understand this application is not valid and coverage is not effective if I do not meet the eligibility requirements outlined in the Case Western Reserve University Student Medial Plan brochure.

The effective date of my coverage shall be the date on which the Health Service receives payment along with this application. Coverage will terminate January 15, 2024.

SIGNATURE OF STUDENT _____ DATE_____

HEALTH SERVICE REPRESENTATIVE _____ DATE _____

IMPORTANT: This form cannot be accepted and will not be effective if it is incomplete. This payment applies for one semester or the remainder thereof.

The Student Medical Plan brochure is located online at
https://case.edu/studentlife/healthcounseling/medical-plan