THE UNIVERSITY OF TENNESSEE
Health Science Center

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UNIVERSITY OF TENNESSEE
GRADUATE MEDICAL EDUCATION PROGRAM
INSURANCE DECLINATION FORM

(Complete only if declining UT health insurance coverage)

I hereby agree that I have been offered the Graduate Medical Education Program's Insurance Plan and have decided not to take advantage of this offer since I have similar coverage elsewhere. I also understand that I will have to provide evidence of insurability for myself and, if applicable, my dependents if I wish to enroll at a later date; and I understand acceptance is not guaranteed at that time. Copy of other health insurance card must be provided.

(PLEASE PRINT)

My current group coverage is as follows:

INSURANCE COMPANY NAME _____

GROUP POLICY NUMBER _____

NAME OF POLICYHOLDER (if not you) _____

EMPLOYER'S NAME _____

_____ _____
DATE NAME OF RESIDENT (Please print)

_____
SIGNATURE OF RESIDENT