



OPT-OUT REVERSAL FORM

I am seeking to reverse my opt out and opt back into the Foreign Health because my MCP is no longer valid.

I acknowledge that by opting in myself and/or my dependents, I will be financially liable to pay the Foreign Health Fee for myself for every semester that I am a registered student at Memorial University of Newfoundland. In the event that I no longer require coverage under Memorial's Foreign Health Insurance, I may make application to the Internationalization Office to cancel the insurance by way of completing an opt out of the Foreign Health Insurance prior to the opt out deadline.

Student Name: _____ Student #: _____

Student Signature: _____ Date: _____

Date of MCP expiry: _____ (dd/mm/yyyy)

Internationalization Office
Acceptance and Approval _____ Date: _____

THIS FORM MUST BE EMAILED TO nclark@mun.ca

All personal information collected on this form will be used solely for the administration and management of the foreign health insurance plan as well as those health and dental plans run by Memorial's student union groups. Personal information is collected under the general authority of the Memorial University Act (RSNL 1990 Chapter M-7) for the purposes of program administration and health insurance enrollment. Questions about this collection and use of personal information may be directed to the Internationalization Office at 709-864-8895.

For Office Use Only	Added to:	<input type="checkbox"/> Banner Fall	<input type="checkbox"/> Banner Winter	<input type="checkbox"/> Banner Spring
	Initials:	_____	_____	_____
	Added to:	<input type="checkbox"/> List Fall	<input type="checkbox"/> List Winter	<input type="checkbox"/> List Spring