archcare
The Continuing Care Community
of the Archdiocese of New York

2021 WAIVE MEDICAL FORM

FIRST NAME	LAST NAME
LOCATION/FACILITY	SSN

Please check the box that applies to you:

( ) I waive all medical coverage.

( ) I currently have active medical coverage and will provide proof.

I hereby attest that the above statement about my medical coverage is accurate. If any changes in my outside medical coverage occur I will notify ArchCare immediately.

SIGNATURE	DATE

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