LABETTE COMMUNITY COLLEGE
AFFIDAVIT OF NO INSURANCE

COMPLETE THIS FORM ONLY IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE

I, _____, **do not have insurance** or any type of accident
Student-Athlete Name
and health plan or service plan under which I am covered. I agree that, should it be determined at a later date that I have collectable coverage, I will reimburse the insurance company which handles coverage for Labette Community College to the extent of any collectable amount. I understand that Labette Community College's secondary coverage will take effect provided I and/or my parent/guardian have supplied the needed verification of no insurance coverage.

Signature of Student: _____ Date: ____/____/____

Signature of Parent/Guardian: _____ Date: ____/____/____
(Signature Required If Student-Athlete Under 18)