University of Rochester Insurance Waiver Appeal Form

Instructions for Form Completion

Section I – This section is to be completed by the student.

1. Please print all entries.

2. If the UR Student ID is unknown, please leave the space blank.

3. Be sure to include the country code if the phone number is from outside the US.

3. **Send the form to the insurance company for completion of Section II.**

Section II – This section must be completed by the Health Insurance Company or if an Employer-sponsored plan, may also be completed by the Employer’s Human Resource Benefit Administrator. (If self-insured, the insurance company is required to verify coverage.)

1. Please print all entries.

2. The representative/administrator completing the form should be someone who can communicate in English. The person will be contacted by University Health Service to verify the accuracy of the coverage information.

3. If the insurance plan the individual has purchased does not meet all required criteria, please let the insured person know. Do not submit an appeal form if all required coverage criteria are not met.

4. If there is no group or policy number, please leave the space(s) blank.

5. **Fax the fully completed form to University Health Service at 585-756-0263.** Keep a copy for insurance company records and send a copy to the person who asked you to complete the form.
University of Rochester Insurance Waiver Form
Copies of Insurance policies are not acceptable.

The University of Rochester requires all full-time students to maintain health insurance coverage for medical care, mental health, and catastrophic illness and injury. Students may satisfy the insurance requirements through public, private or employer sponsored plans that meet certain minimum criteria. All requests for waiver are due no later than 30 days after notice of admission. Late submissions will not be accepted. Those failing audit must enroll in the UR-sponsored plan. Students with approved waivers are responsible for charges up to their plan deductible and/or due to possible out of network status for care in Rochester, New York and elsewhere.

Section I – To be completed by the Student.

Date sent to insurance company: ______________

Student Name: Last: ___________________ First: ______________

UR Student ID: _________________ Birthdate: ______________ Email Address: ________________

Section II – To be completed by Insurance Company or Human Resource Benefit Administrator. Please print.

Insurance Company Information:

Name: _____________________________________________________ Phone #:___________________________

Address:____________________________________________________________________________________

Guarantor’s Name:_________________________________________Birthdate: ____________________________

[This is the name of the primary person on the plan. If you are on your parent’s plan, your parent is the guarantor.]

Guarantor’s ID Number: _________________________________

Group Number: ______________________________Policy Number: _____________________________________

Effective Date: ______________________________ Expiration Date (if any)_______________________________

I hereby attest that this plan meets ALL of the following University of Rochester criteria.

1. The plan covers a minimum of $500,000 US in medical benefits for illness, accident or injury per plan year.
2. The plan has a deductible of $5,000 US or less per covered person per plan year.
3. The plan covers prescription medications to a minimum of $100,000 US per plan year.
4. The plan covers all pre-existing health conditions without restriction.
5. The plan covers mental health conditions at the same level as other medical conditions.
6. The plan covers care related to pregnancy and delivery for female students.
8. The plan must cover care for injuries related to intercollegiate athletics and recreational activities.
9. The plan is in effect as of August 1, 2015 and will remain in effect through the academic year (i.e. July 31st, 2016 or December 31, 2015 for students graduating in December.)

REQUIRED: Printed name and signature of the person from the insurance company or Human Resource Department who is attesting the student’s plan meets the University criteria.

____________________________________________________________________________________________

REQUIRED from ATTESTER:

PRINTED NAME

SIGNATURE

____________________________________________________________________________________________

REQUIRED from ATTESTER:

PHONE NUMBER

E-MAIL ADDRESS

DATE SENT to University Health Service, University of Rochester: ______________

Return to UHS addressed to:
University of Rochester Insurance Waiver Appeal
FAX (585) 756-0263, insurance@uhs.rochester.edu,
OR mail to University Health Service (UHS), PO Box 270617, Rochester, NY 14627

FOR UHS USE

Date Received by UHS: ____________

Date Verified: ____________

Waiver Approved: ☐ YES ☐ NO

Initials/UHS Staff: ______________