University of Rochester Insurance Waiver 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.

4.  **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.
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.

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**Section I – To be completed by the Student.**

*Date sent to insurance company: _______________

Please print.

Student Name: Last: ____________________  First: ______________  Phone Number: ______________________

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

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**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)________________________________

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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, 2016 and will remain in effect through the academic year (i.e. July 31st, 2017 or December 31, 2016 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.

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**REQUIRED from ATTESTER:**

PRINTED NAME  SIGNATURE

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**REQUIRED from ATTESTER:**

PHONE NUMBER  E-MAIL ADDRESS

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**DATE SENT to University Health Service, University of Rochester:** _______________

*Return to UHS addressed to:*

**University of Rochester Insurance Waiver Appeal**  
**FOR UHS USE**

FAX (585) 756-0263, insurance@uhs.rochester.edu,  
OR mail to University Health Service (UHS),

PO Box 270617, Rochester, NY 14627

Date Received by UHS: ____________  Date Verified: ____________  Waiver Approved: □ YES □ NO

Initials/UHS Staff: _________________

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KAM 05-04-16