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 United States.
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 a self-insured employer, the insurance company is required to verify coverage.)

1. Please print all entries.
2. The representative/administrator completing the form must be able to communicate in English. The person will be contacted by University Health Service to verify the accuracy of the coverage information.
3. To the Insurance Representative - If the insurance plan the individual has purchased does not meet all required criteria, please advise the insured person. Do not submit an appeal form to the University 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 **with a copy of both the front and back sides of the insured person's membership ID card** to University Health Service, FAX 585-756-0263**.** Keep a copy for insurance company records and send a copy to the person who asked you to complete the form.

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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: _____**
Please print.
Student Name: Last: _____ First: _____ Phone Number: _____
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.]

Member'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 must cover a minimum of $500,000 US in medical benefits for illness, accident or injury per plan year.
2. The plan must have a deductible of no more than $5,000 US per covered person per plan year. (Note: Plans without deductible meet this requirement.)
3. The plan must cover prescription medications to a minimum of $100,000 US per plan year.
4. The plan must cover all pre-existing health conditions without restriction.
5. The plan must cover mental health conditions at the same level as other medical conditions.
6. The plan must cover care related to pregnancy and delivery for female students.
7. The plan must cover care for self-inflicted injury, attempted suicide, and suicide.
8. The plan must cover care for injuries related to intercollegiate athletics and recreational activities.
9. The plan must cover healthcare (non-emergency) in the Rochester, New York region.
10. The plan is in effect as of August 1, 2019 and will remain in effect through the academic year (i.e. July 31st, 2020 or December 31, 2019 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.
MUST ALSO PROVIDE A COPY OF THE FRONT AND BACK OF THE MEMBER'S ID CARD

_____

REQUIRED from ATTESTER: PRINTED NAME SIGNATURE

_____

DATE 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),

FOR UHS USE
Date Received by UHS: _____
Date Verified: _____
Waiver Approved: ☐ YES ☐ NO
Initials/UHS Staff: _____