

Petition to WAIVE
The University of Chicago Student Health Insurance Plan after the Published Enrollment Deadline

Student's Name: _____ Student ID: _____ Date of Birth: ____/____/_____

Mailing Address: _____

Phone Number: (_____) _____ Email: _____

Waive Beginning: (circle one) Autumn Winter Spring Summer

Please fill in all of the above information so we can contact you with any questions.

Waiver: I certify that I am insured under the following medical insurance plan and that it meets the following criteria.

If your coverage does not meet each of these conditions, you may not waive. You will remain enrolled in the University Student Health Insurance Plan (U-SHIP). If you do not know whether your coverage meets these conditions, contact your health insurance plan administrator to obtain current, accurate information about your plan before completing this form.

Comparable Coverage Checklist	
Type of Plan: (please circle)	Individual / Family
Does Your Insurance Policy Provide:	Your Plan Meets or Exceeds
Routine and emergency care provided in the Chicago area (or local area where student will be residing and studying for the academic year)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Annual Out-of-Pocket Maximum (individual =/ < \$7,150; family =/ < \$14,300)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coverage for Pre-existing conditions	<input type="checkbox"/> YES <input type="checkbox"/> NO
Inpatient Hospital Benefits (including labs, x-rays, and misc. expenses)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Emergency Room Visits and Treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Outpatient Benefits (e.g. Physician office visits, labs, Physical Therapy, radiology, etc.)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Inpatient Mental Health Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO
Outpatient Mental Health Benefits	<input type="checkbox"/> YES <input type="checkbox"/> NO
Prescription Drug coverage	<input type="checkbox"/> YES <input type="checkbox"/> NO
Maternity and Newborn Care	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pediatric Services	<input type="checkbox"/> YES <input type="checkbox"/> NO
Rehabilitative Services or Devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
Medical evacuation and repatriation coverage (Required for F1/J1 students and other students traveling/studying abroad during academic year) otherwise exempt - check yes.)	<input type="checkbox"/> YES <input type="checkbox"/> NO

Insurance Plan Information:
Please provide a copy of your insurance card.
Please check: <input type="checkbox"/> PPO <input type="checkbox"/> HMO
<input type="checkbox"/> OTHER: Specify _____
Annual Deductible \$ _____
Reason why this waiver is being submitted after the deadline:

Will your insurance plan provide coverage from September 1, 2017 to August 31, 2018, or through the end of your academic program, whichever comes first? YES NO

Subscriber Name: _____

Relationship of Policyholder to Student: Parent/Guardian Spouse/Domestic Partner Self

Policy or Subscriber Number: _____ Group Policy Name: _____

Group Policy Number: _____ Insurance Company: _____

Insurance Company Telephone Number – must be a U.S. number (for verification): _____ Insurance Company State: _____

Policy issued in the United States Claims Administrator located in the United States

I understand that I am requesting to waive my student insurance coverage. My request is being taken under consideration only because I have a valid reason why my waiver was not received before the deadline date and I have comparable coverage through another insurance company. I further understand that I am responsible for all my medical expenses. I understand that I will not be allowed to enroll in the student insurance plan again until the next policy year. I understand this petition is subject to approval in accordance with University policy.

 Date Student Signature

By checking "YES", I give the the University of Chicago permission to share my health insurance enrollment information with YES NO the University of Chicago Health Services as well as approved providers of in-patient psychiatry services for UChicago students (if needed). The purpose of this disclosure is to expedite the verification student insurance status and thereby enable faster access to health care.

Students: Complete this form and return it to: **On-Campus Insurance Office**
 Woodlawn Social Service Center
 950 E. 61st Street, Suite 300A
 Chicago, IL 60637
 or by email to uchicagoadvocates@uhcsr.com



UnitedHealthcare StudentResources does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

- ATTENTION: Language assistance services, free of charge, are available to you. Please call 1-866-260-2723.
- ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-260-2723.
- 請注意：如果您說中文 (Chinese)，我們免費為您提供語言協助服務。請致電：1-866-260-2723.