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 Representative.

1. Please print all entries.
2. The Insurance company representative completing the form should be someone who can communicate in English. The person will be contacted by a University Health Service representative 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. Students with insurance companies from outside the United States must complete this form to appeal enrollment in the University-sponsored plan**. Fall submissions are due by September 15 (January 31 for winter/spring term) or within 30 days of admission.** All requests will be audited. Late submissions **WILL NOT** be accepted. Those failing audit will be enrolled 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: _____Phone Number: _____

UR Student ID: _____ Birthdate: _____ Gender: _____

Email Address:_____

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

Insurance Company Information:

Name: _____ Phone #:_____

Address:_____City/State/Zip:_____

Guarantor's Full Name: _____ Birthdate: _____ Gender: _____

[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, 2023 and will remain in effect through the academic year (i.e. July 31st, 2024 or December 31, 2023 for students graduating in December.)

Medicaid Health Plans will not be attested to by insurance company, please contact your student health insurance advisor for instructions on how to complete this form. Email: healthinsuranceemail@uhs.rochester.edu

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: Insurance Company Representative's Printed Name and SIGNATURE

_____

Required: Insurance Company Phone Number and Email Address

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

Return to:

University of Rochester Insurance Waiver

FAX (585) 756-0263, insurance@uhs.rochester.edu

or

University Health Service, PO Box 270617, Rochester, NY 14627