

Health Insurance Waiver Request Form Acknowledgement of Financial Responsibility

Name:	ID:
Email:	Phone:

Alfred University requires health coverage for all international students. To make sure that you are covered, we automatically enroll you in Alfred University's health insurance plan and the cost is applied to your student bill.

If you do not want to be enrolled in the Alfred University health insurance plan, you must complete both pages of this form and submit it and all supporting documentation by the deadline on page 2.

Section 1: Proof of Acceptable Non-Alfred University Health Insurance Coverage

You must have proof of a different plan that meets the following requirements. Please initial next to each item to show that you understand and that you have confirmed that your plan has the coverage indicated:

_____ Medical benefits of at least USD \$100,000 per accident or illness;
(If you get sick or have an accident, will your insurance provider pay at least USD \$100,000 for your care?)

_____ A deductible not to exceed USD \$500 per accident or illness;
(In an insurance policy, the "deductible" is the amount of money that you (as the patient) must pay to the hospital or doctor's office before the insurance provider will pay any expenses. Does your insurance plan require that you pay more than USD \$500 to get care?)

_____ Medical evacuation coverage at a minimum of USD \$50,000
(If you suffer a medical emergency and require transportation back to your home country, does your insurance provider cover medically-necessary transportation up to USD \$50,000?)

_____ Repatriation of remains at a minimum of USD \$25,000;
(We hope this does not happen, but we have to ask: Should you die while in the U.S., will your insurance provider arrange and pay up to USD \$25,000 for the expenses to return your remains to your home country?)

Section 2: Reason for not being enrolled in Alfred University's plan

I request to waive (be unenrolled from) Alfred University's health insurance plan for the following reason:
(Check only one box)

I am a student enrolled in an Alfred University course **and** have met the requirements for health coverage. *For students who obtain private insurance or New York State Medicaid.

Must attach:

- Documentation (e.g., policy) to show fulfillment of health coverage requirement
- Health Insurance Card

Health Insurance Company Name:	Policy Number:
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I am covered under mandatory student health coverage from another university, ISEP, or home government program (e.g., SACM)

Must attach:

- Documentation of alternate student health coverage that includes the name of company, your name, and coverage dates
- Health Insurance Card
- Contact information for official who can verify the terms

I am attending Alfred University for one semester and only need coverage for that semester. The semester I am attending Alfred University is _____. Please only enroll me for this semester, and waive (remove) my coverage for the semester I have checked below. I understand that this cannot be changed at a later date. I waive AU coverage during:

Fall Semester (August 14th-January 14th) Spring Semester (January 15th-August 13th)

(Our coverage is based on an annual agreement beginning August 14 and ending on August 13. For your convenience we have separated the agreement into semester dates)

Section 3: Waiver Agreement

I understand that medical services in the United States can be very expensive (costing, in some cases, hundreds to thousands of U.S. dollars). I understand that I am personally and fully responsible for my medical expenses during the time of any granted waiver. If a waiver is approved, I am cancelling my eligibility for the Alfred University Student Health Plan for the period and understand that I will not be permitted to enroll during that period. I understand that if I have any Wellness Center service claims during the period, claims may be added to my student account for payment.

Your signature confirms understanding of the waiver agreement and that the selections above are true and accurate to the best of your knowledge.

Signature

Date

This completed and signed form and requested documentation must be received by the following deadlines:
August 30th for Fall Semester/ January 30th for Spring Semester

Return completed form for review to the Alfred University Wellness Center, located on the corner of Park and Terrace.

Mail: 1 Saxon Drive, Alfred, NY 14802 (Attn: Wellness Center)

Fax: 607-871-2631

Since each waiver request must be individually researched by a Wellness Center staff and health coverage carrier, please allow us up to 5 business days for processing. The charge to your student account will not be removed until your waiver is approved. A completed form does not guarantee approval. You will be notified by email about your approved or denied status.

*Approval must be given annually (i.e., you need to complete and submit a waiver form each academic year)

Wellness Center use only: Approved Denied; Reason _____

Date Reviewed: _____ Initials _____