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)	☐ YES ☐ NO
Annual Out-of-Pocket Maximum (individual =/< $7,900; family =/< $15,800)	☐ YES ☐ NO
Coverage for Pre-existing conditions	☐ YES ☐ NO
Inpatient Hospital Benefits (including labs, x-rays, and misc. expenses)	☐ YES ☐ NO
Emergency Room Visits and Treatment	☐ YES ☐ NO
Outpatient Benefits (e.g. Physician office visits, labs, Physical Therapy, radiology, etc.)	☐ YES ☐ NO
Inpatient Mental Health Benefits	☐ YES ☐ NO
Outpatient Mental Health Benefits	☐ YES ☐ NO
Prescription Drug coverage	☐ YES ☐ NO
Maternity and Newborn Care	☐ YES ☐ NO
Pediatric Services	☐ YES ☐ NO
Rehabilitative Services or Devices	☐ YES ☐ NO
Medical evacuation and repatriation coverage (Required for F1/J1 students and other students traveling/studying abroad during academic year) otherwise exempt - check yes.)	☐ YES ☐ NO

Insurance Plan Information:
Please provide a copy of your insurance card.
Please check: ☐ PPO ☐ HMO
☐ OTHER: Specify _____
Annual Deductible $
Reason why this waiver is being submitted after the deadline:

Will your insurance plan provide coverage from September 1, 2020 to August 31, 2021, or through the end of your academic program, whichever comes first? ☐ YES ☐ NO

Policy Holder Name: _____ Policy Holder DOB: _____ Policy Holder Gender: _____

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

Member ID or Policy Number: _____ Group Policy Name: _____

Group Number: _____ Insurance Company Name: _____

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

☐ 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 the University of Chicago Heath 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. ☐ YES ☐ NO

Students: Complete this form and return it to:

On-Campus Insurance Office
950 E. 61st Street, Suite 300A
Chicago, IL 60637
or by email to uchicagoadvocates@uhcsr.com

UnitedHealthcare®

20COL4075

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.