UChicago Student Wellness

# MID-YEAR UPDATE OF INSURANCE INFORMATION

Please use this form to update alternate insurance information submitted on your original waiver application for the 2026-2027 academic year.

**Please return this completed form by email to uchicagoadvocates@uhcsr.com within 31 days of the new/updated policy taking effect:**

Please provide *all* of the information requested. **Insurance Update forms will not be accepted if the information is incomplete.** If you have questions about completing this form, please e-mail uchicagoadvocates@uhcsr.com.

**Student Name:** _____ **U of C ID #** *(8-digit)*:_____

**Daytime Phone:**_____**Date of Birth** *(mm/dd/yyyy)*:_____

**Student UChicago E-mail:** _____

## SECTION A: INSURANCE POLICY AND SUBSCRIBER INFORMATION – PRIMARY PLAN

**Policy Holder First Name**:_____**Last Name:** _____

**Student Relationship to Insured (policy holder)**: ☐ Self ☐ Spouse ☐ Child

**Insurance Company Name**:

_____

**Policy or Subscriber Number:** _____

**Insurance Type:** ☐ HMO ☐ PPO ☐ EPO ☐ POS ☐ Military ☐ Indemnity

*(please check one)* ☐ Open Access ☐ Medicaid/care ☐ Nat'l Health Service ☐ Other

**Insurance Co. Phone**: _____ **Insurance Co. State**:_____

*(Used to verify coverage. Must be a toll-free U.S. number.)*

## **SECTION B:** COMPARABILITY OF COVERAGE

| | |
|---|---|
| Type of Plan: *please specify individual or family** | |
| Annual premium *(please list dollar amount)* | $ |
| Annual deductible *(please list dollar amount)* | $ |
| Annual out-of-pocket maximum *(please list dollar amount)*** | $ |
| Annual HSA/HRA contribution *(please list dollar amount, if applicable)* | $ |

**individual plans provide coverage for one person; family plans provide coverage for a couple, or adults and related dependents*
***individual plan out-of-pocket max may not exceed $10,600; family plan out-of-pocket max may not exceed $21,200, per the ACA.*

| Alternate insurance plans also must provide: | *Please indicate if your plan includes coverage for the following:* | |
|---|---|---|
| | Yes | No |
| Routine non-emergency, and emergency, care ***provided in the Chicago area***+ (or the local area the student will be residing and studying in for the academic year) | | |
| Treatment for pre-existing conditions (with no waiting periods or exclusions) | | |
| Essential health benefits as defined by the Affordable Care Act (ACA): (unlimited annual lifetime benefit for each of the following) | | |
| • Outpatient care (ambulatory patient services) | | |
| • Emergency Services | | |
| • Hospitalization (treatment for inpatient care) | | |
| • Mental health services and addiction treatment | | |
| • Prescription drugs | | |
| • Maternity and newborn care | | |
| • Rehabilitative services and devices | | |
| • Laboratory services | | |
| • Inpatient mental health care | | |
| • Preventive services, wellness services, and chronic disease treatment | | |
| • Pediatric services | | |
| Plan has a claims administrator based in the U.S. | | |
| Plan has a U.S. telephone number | | |
| Plan has a U.S. address for submission of claims | | |
| Insurance policy was issued and underwritten from within the U.S. | | |
| Medical evacuation and repatriation expenses (for students who will reside more than 100 miles from their permanent address during the academic year) | | |
| Active coverage from the day student arrives on campus through either August 31, 2026 OR the end of their academic program (whichever comes first) | | |

+ Medicaid and HMO plans issued outside IL generally do not meet this requirement for non-emergency coverage in the Chicago area, unless a specific rider is included for out of area coverage

## **SECTION C:** VERIFICATION OF INFORMATION

☐ **Permission to Disclose Information** *(optional)*

I give the University of Chicago permission to share my health insurance enrollment information with UChicago Student Wellness providers and/or staff (if needed). The purpose of this disclosure is to expedite the verification of student insurance status and thereby enable faster access to health care information and services.

*Please agree to the following statements to complete your waiver application (required):*

☐ **Notification Requirement**

I agree to notify the University of Chicago of any additional changes in medical coverage no later than 30 days after such a change has taken place. I understand that, I must contact the United Healthcare On-Campus Insurance Office, phone: (773) 834-4543 (option #2); email: uchicagoadvocates@uhcsr.com.

☐ **Waiver Audit Acknowledgement**

I understand that my insurance information may be audited, after my waiver application has been updated through this form, to ensure that my policy is active, and that it meets all of the University of Chicago's comparable coverage requirements. If an audit finds that my policy fails to meet the University's requirements for alternate insurance, I will have 10 business days either to supplement my existing coverage or find alternate insurance that meets these requirements; otherwise, I will be reenrolled in U-SHIP for the entire plan year (or relevant time period) and billed the annual premium (or appropriate installment).

**Student Signature:**_____ **Date:**_____