**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 |
| Annual out-of-pocket maximum (per Affordable Care Act, individual plans must be =/< $9,100 family plans must be =/< $18,200) | |
| Non-emergency as well as emergency care provided in the Chicago area (or local area where student will be residing and studying for the academic year) | ☐ YES ☐ NO |
| Treatment for pre-existing conditions (with no waiting periods or exclusions) | ☐ YES ☐ NO |
| Essential health benefits as defined by the Affordable Care Act (ACA)<br>Unlimited benefit for each of the following: | ☐ YES ☐ NO |
| • Outpatient care (ambulatory patient services) | ☐ YES ☐ NO |
| • Emergency Services | ☐ YES ☐ NO |
| • Hospitalization (treatment for inpatient care) | ☐ YES ☐ NO |
| • Mental health services and addiction treatment | ☐ YES ☐ NO |
| • Prescription drugs | ☐ YES ☐ NO |
| • Maternity and newborn care | ☐ YES ☐ NO |
| • Rehabilitative services and devices | ☐ YES ☐ NO |
| • Laboratory services | ☐ YES ☐ NO |
| • Inpatient mental health care | ☐ YES ☐ NO |
| • Preventive services, wellness services, and chronic disease treatment | ☐ YES ☐ NO |
| • Pediatric services | ☐ YES ☐ NO |
| Plan has a claims administrator based in the U.S. | ☐ YES ☐ NO |
| Plan has a U.S. telephone number | ☐ YES ☐ NO |
| Plan has a U.S. address for submission of claims | ☐ YES ☐ NO |
| Insurance policy was issued in the U.S. | ☐ YES ☐ NO |
| Coverage for medical evacuation and repatriation expenses:<br>• Required for all F1 / J1 students (specific J-1 insurance requirements can be found here)<br>• Required for all other students ONLY when they will be studying/ traveling/ doing research out of the United States during the current academic year (otherwise exempt and can check "yes")<br>Department of State website address for the J-1 insurance requirements:<br>https://j1visa.state.gov/programs/college-and-university-student/#participants | ☐ YES ☐ NO |
| Active coverage from the day student arrives on campus through August 31, 2024 OR the end of their academic program (whichever comes first) | ☐ YES ☐ NO |

| Insurance Plan Information: |
|---|
| Please Provide a copy of your insurance card. |
| Please check: ☐ PPO ☐ HMO |
| ☐ OTHER: Specify |
| Annual Deductible $ |

Will your insurance plan provide coverage from September 1, 2023 to August 31, 2024, or through the end of your academic program, whichever comes first? ☐ YES ☐ NO

Reason why this waiver is being submitted after the deadline: _____

_____

_____

_____

_____

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 UChicago Student Wellness 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

**Non- PhD Students:** Complete this form and return it to:

Student Insurance Office
Student Wellness Center
840 East 59th Street
Chicago, IL 60637
or by email to uchicagoadvocates@uhcsr.com

**PhD Students:** Complete this form and return electronically to:

Celia Bergman - Program Manager
Campus and Student Life
cbergman@uchicago.edu