

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 ≤ \$8,700 family plans must be ≤ \$17,400)	
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)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Treatment for pre-existing conditions (with no waiting periods or exclusions)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Essential health benefits as defined by the Affordable Care Act (ACA)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Unlimited benefit for each of the following:	
• Outpatient care (ambulatory patient services)	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Emergency Services	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Hospitalization (treatment for inpatient care)	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Mental health services and addiction treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Prescription drugs	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Maternity and newborn care	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Rehabilitative services and devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Laboratory services	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Inpatient mental health care	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Preventive services, wellness services, and chronic disease treatment	<input type="checkbox"/> YES <input type="checkbox"/> NO
• Pediatric services	<input type="checkbox"/> YES <input type="checkbox"/> NO
Plan has a claims administrator based in the U.S.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Plan has a U.S. telephone number	<input type="checkbox"/> YES <input type="checkbox"/> NO
Plan has a U.S. address for submission of claims	<input type="checkbox"/> YES <input type="checkbox"/> NO
Insurance policy was issued in the U.S.	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coverage for medical evacuation and repatriation expenses: • Required for all F1 / J1 students (specific J-1 insurance requirements can be found here) • 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")	<input type="checkbox"/> YES <input type="checkbox"/> NO
Active coverage from the day student arrives on campus through August 31, 2023 OR the end of their academic program (whichever comes first)	<input type="checkbox"/> YES <input type="checkbox"/> 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 ☐ YES ☐ NO
coverage from September 1, 2022 to
August 31, 2023, or through the end
of your academic program, whichever
comes first?

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

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。

