Medical Student Insurance Waiver Petition

Part I: Conditions of Agreement

I understand that if I waive medical coverage, my dependents (if any) and I will not be entitled to claim any benefits under the medical plan offered by NYU School of Medicine (SOM).

I understand that if I do not meet the conditions set forth in this waiver or it is not completed in its entirety, I am not eligible to waive and must enroll in the NYU School of Medicine health insurance plan, which will remain in effect for the entire academic year, unless I qualify at a later date and follow the required steps to waive.

I understand that I must submit this waiver by the deadline indicated or I will be default enrolled in the NYU School of Medicine health insurance plan. In the event I submit my waiver form after the deadline, my election will take effect the first day of the month following my submission.

I understand that the School of Medicine has strongly recommended that I contact my insurance carrier and review my Benefits Summary in order to ensure that the information provided is accurate.

I understand that this waiver is in effect for the entire academic year unless I elect to enroll for coverage during the year. I understand that to enroll, I will be required to complete enrollment forms and my election will take effect the first day of the month following my submission.

I understand that if I lose my current coverage, I must enroll in the NYU School of Medicine plan. I understand that to enroll, I will be required to complete enrollment forms and my election will take effect the first day of the month following my submission.

I understand that I must complete a new waiver form at the start of each academic year. Otherwise, I will be enrolled automatically in the SOM plan.

Part II: Criteria for Comparable Insurance Plan

- ☐ My plan covers all medically necessary out-of-network care, in addition to emergency services, in the New York City area.
- ☐ My plan includes prescription drug coverage.
- ☐ My plan covers inpatient AND outpatient mental health care and substance abuse treatment in the New York City area (must include a minimum of 20 outpatient visits per year) including out-of-network care.
- ☐ The minimum benefit for my coverage is $250,000 per condition per calendar year.
- ☐ My coverage is effective on July 1, 2018 through August 31, 2019. In the event my coverage ends during the academic year, I understand it is my obligation to enroll under the medical plan offered by NYU School of Medicine. I understand that to enroll, I will be required to complete enrollment forms and my election will take effect the first day of the month following my submission.
- ☐ My coverage is provided by a company licensed to do business in the United States and has a U.S. claims office and telephone number. Foreign state government plans do NOT meet this requirement.

Part III: Student Information

Name: _____ Class Year: 2023 2022 2021 2020 2019 Other: _____

DOB: _____ SS# _____ Phone: _____

Email: _____

MEDICAL

Carrier Name: _____

Member ID/Certificate# _____

Group/Plan # _____

Name under whom you are subscribed (i.e. parent) _____

PRESCRIPTION (REQUIRED FOR WAIVER APPROVAL)

Prescription Processor _____
(Example: Medco, Caremark, Express)

Member # _____

I have reviewed my current plan benefits and certify that the information I have provided above is complete and accurate. I understand that failure to provide complete and accurate information may result in my being required to enroll in the NYU School of Medicine student health insurance plan in accordance with the insurance company's provisions and be billed at the current rate and/or may result in my inability to receive coverage for necessary care.

_____ _____
Student Signature Date

Updated: September 25, 2018