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 (_____)_____ 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.

Does Your Insurance Policy Provide:	Minimum Requirement	Your Plan Meets or Exceeds
Coverage for at least 80% of CC* both emergency as well as non-emergency (e.g. routine or specialty care), provided in the Chicago area.	YES	☐ YES ☐ NO
Lifetime Maximum Coverage	$1,000,000	☐ YES ☐ NO
Coverage for Pre-existing conditions	80% of CC	☐ YES ☐ NO
Inpatient Hospital Benefits (including labs, x-rays, and misc. expenses)	80% of CC	☐ YES ☐ NO
Emergency Room Visits and Treatment	80% of CC	☐ YES ☐ NO
Outpatient Benefits (e.g. Physician office visits, labs, Physical Therapy, radiology, etc.)	80% of CC	☐ YES ☐ NO
Outpatient Mental Health Benefits	80% of CC	☐ YES ☐ NO
Inpatient Mental Health Benefits	80% of CC up to 30 days per year	☐ YES ☐ NO
Prescription Drug coverage	70% of CC	☐ YES ☐ NO
Ambulance coverage	80% of CC	☐ YES ☐ NO
Medical evacuation and repatriation coverage (Required for students who will reside more than 100 miles from their permanent address during the academic year)	Yes, provided through this medical insurance or through a life insurance policy or supplemental plan that I have purchased (Students residing less than 100 miles from their permanent residence during the academic year, indicate "Yes").	☐ YES ☐ NO

*CC = Physician/Hospital Customary Charges

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

_____

_____

_____

Will your insurance plan provide coverage from September 1, 2013 to August 31, 2014, or through the end of your academic program, whichever comes first? ☐ YES ☐ NO

Subscriber Name: _____

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

Policy or Subscriber Number: _____ Group Policy Name: _____

Group Policy Number: _____ Insurance Company: _____

☐ Check this box if insured through a foreign government or the U.S. Armed Services.

Insurance Company Telephone Number – must be a U.S. number (used to verify coverage – not required if box above is checked): _____

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 UnitedHealthcare **Student**Resources approval and their decision is FINAL.

_____ _____

Date Student Signature

By checking "YES", I give the Registrar's Office permission to share my **health insurance enrollment information** with University of Chicago student health services as well as Mercy Hospital (the provider of in-patient psychiatry services for U Chicago students). The purpose of this disclosure is to expedite the verification of 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**
Woodlawn Social Service Center
950 E. 61st Street, Suite 300A
Chicago, IL 60637

UnitedHealthcare

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