Assumption College 2014 Spring Continuing Education Students and Graduate Students Waiver

THIS WAIVER MUST BE COMPLETED IN ITS ENTIRETY, SIGNED AND RETURNED PRIOR TO JANUARY 28, 2014 TO THE FINANCE OFFICE OR THE COLLEGE WILL BE OBLIGATED BY MASSACHUSETTS STATE LAW TO ENROLL YOU IN THE COLLEGE'S STUDENT HEALTH PLAN AND TO BILL YOU ACCORDINGLY.

STUDENT INFORMATION

First Name: _____ Last Name: _____

Email: _____ Student ID Number: _____

INSURANCE INFORMATION

Insurance Company/Health Plan Name: _____

Policy Number: _____ Group Number: _____

Insurance Company Address: _____

Insurance Company City: _____ Insurance Company State: _____

Insurance Company Zip Code: _____ Insurance Company Phone: _____

Please answer the following questions to determine if your current coverage exempts you from purchasing the school's recommended insurance coverage.

☐ Yes	☐ No	1. The insurance company is based in the United States and has a US telephone number and address for submission of claims.
☐ Yes	☐ No	2. The plan provides both emergency and non-emergency health care and mental health care benefits.
☐ Yes	☐ No	3. The plan provides inpatient and outpatient mental health care and chemical dependency benefits.
☐ Yes	☐ No	4. The plan has local participating hospitals, physicians, pharmacies, and mental health care providers within a 50 mile radius of the campus.
☐ Yes	☐ No	5. The plan benefit maximum is at least $500,000 per policy year.
☐ Yes	☐ No	6. The plan provides coverage for prescription medications.
☐ Yes	☐ No	7. My plan has coverage for pre-existing conditions.
☐ Yes	☐ No	8. If the student will be traveling abroad, the plan has medical evacuation and repatriation coverage. This requirement may also be fulfilled by purchasing separate medical evacuation and repatriation coverage.

The submission of this waiver form including all information herewith constitutes truthful and accurate statements by me. If inaccurate information is submitted I will be enrolled immediately into the student health insurance plan.

I will lose the eligibility to waive the student health insurance plan for the duration of my three-quarter to full time enrollment in a degree-granting program. I will be automatically enrolled into the student health insurance plan offered by Assumption unless documented proof of current enrollment in a comparable health insurance plan designated by the Commonwealth of Massachusetts is provided in person each year.

Signature _____ Date _____