STUDENT HEALTH INSURANCE WAIVER
2017/18 ACADEMIC YEAR

This waiver form is for students charged for the Boston University Student Health Insurance Plan in the Fall 2017 semester. The Fall 2017 waiver deadline is August 3, 2017. Please return the completed form to: Boston University Student Accounting Services, 881 Commonwealth Avenue, lower level, Boston, MA 02215, by email to insmed@bu.edu or by fax to 617-353-3313.

Think Before You Waive: View the Student Health Insurance Guide and determine if the student will have comparable coverage at: http://www.bu.edu/shs/ship/ and review the checklist under Waiving SHIP.

Many health insurance plans offer limited or no coverage if you are out of network. Please contact your current insurance provider and be sure that your plan will cover you for preventive care, primary care, mental health care, hospital care and surgical care as well as prescription drug coverage where the student is studying.

Review Your Health Insurance Decision Guide at http://www.bu.edu/shs/ship/ to determine if waiving the Boston University Student Health Insurance Plan is in your best interest.

STUDENT NAME: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

last name *first name*

BU ID NUMBER : |__|__|__| - |__|__| - |__|__|__|__| **COLLEGE:** |__|__|__|

Insurance company name: ______________________________

Insurance plan name: ______________________________

Insurance company (claims) address: ______________________________

____________________ **Telephone number (customer service):** ____________________

Policy Number / Member id (for student): ____________________ **Group Number (if applicable):** ____________________

Name of Primary Card Holder (subscriber): ______________________________

Card Holder's (subscriber) relationship to student: ☐ self ☐ parent/guardian ☐ spouse

Card Holder's (subscriber) address: ______________________________

- ☐ I certify that the health insurance plan that I have listed on this waiver form is now in force and will be maintained for the remainder of the 2017/2018 academic year.
- ☐ I certify that the health insurance company that I have listed on this waiver form is a U.S. based health insurance carrier (unless the student is studying outside of the U.S.)
- ☐ I certify that the plan listed above does not have an annual nor lifetime dollar limit on coverage.
- ☐ I certify that the plan is **not**: a product with a closed network of providers accessible only for emergency coverage where the student is studying. Examples of these include out-of-area HMO, EPO, and Medicaid plans.
- ☐ I certify that the plan is **not**: a "Health Safety Net" program, MassHealth Limited or the Children's Medical Security Program.

By submitting this form, I certify that I have compared my health insurance plan to the Boston University Student Health Insurance Plan and I have determined the benefits to be at least comparable. I understand that I will be responsible for all medical insurance expenses incurred by me, including deductibles, copays, and charges that may be billed by Boston University Student Health Services, and neither Boston University nor its Student Health Insurance Plan will be responsible. I attest that no claims have been submitted for payment under the Boston University Student Health Insurance Plan for the 2017-2018 policy year. My signature certifies that the above information is true and accurate.

____________________ Student Signature and Date

____________________ Parent/Guardian Signature and Date

**The student signature is required. If the student is below age 18, this form must be co-signed by the parent or guardian*

Please Return to SEA Semester