School of Medicine

Medical Student Insurance Waiver Petition

***This form is to be reviewed, completed, and signed by the student. Completed Waiver Petition Forms must be submitted by July 26, 2010 to avoid default enrollment in the school insurance plan.**

Part I: General Information

Name: ______________________________ Class Year: 2014 ☐ 2013 ☐ 2012 ☐ 2011 ☐ Other: ________

DOB: ____________ SS# ________________ Phone: ____________________________

Email: ____

Local Address: ____

____

Part II: Conditions of Agreement

(Initial next to each statement to indicate that you understand and agree to each of the conditions below)

_____ *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. You may obtain enrollment forms from: http://studentaffairs.med.nyu.edu/student-resources/orientation/class-2014-health-insurance-enrollment-and-waiver-information.*

_____ *I understand that I must submit this waiver by the deadline indicated above or I will be enrolled in the NYU School of Medicine health insurance plan. I further understand that the NYU School of Medicine is not obligated to accept forms submitted after the deadline unless prior written approval has been granted by the Office of Student Affairs* (include any written agreements with this petition).

_____ *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 beginning January 1, 2011, based on a qualifying event. I understand that to enroll, I will be required to complete enrollment forms.*

_____ *I understand that if I lose my current coverage, I must enroll in the NYU School of Medicine plan within 30 days of the termination date or be required to wait until the next open enrollment period.*

_____ *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.*

- over -

Print Student Name (as it appears on page 1): ____

Part III: Waiver Petition

NOTE: If you answer 'no' to any of the four conditions below and/or fail to fully complete the medical and prescription sections on the back, you are NOT eligible to waive the NYU SoM medical plan. You will be contacted to enroll in the school plan. You may obtain enrollment forms from http://studentaffairs.med.nyu.edu/student-resources/orientation/class-2014-health-insurance-enrollment-and-waiver-information.

_____ **YES** _____ **NO** My plan covers necessary out-of-network medical care, in addition to emergency care, in the New York City area, including prescription drug coverage.

_____ **YES** _____ **NO** My plan covers inpatient AND outpatient mental health care and substance abuse treatment in New York City area (must include a minimum of 20 outpatient visits per year) including out-of-network care.

_____ **YES** _____ **NO** The minimum benefit for my coverage is $250,000 per condition per calendar year.

_____ **YES** _____ **NO** I will be covered under my current plan through December 31, 2010.

MEDICAL (REQUIRED FOR WAIVER APPROVAL)

Carrier Name: ______________________________

Claim Address ______________________________

____

Member ID/Certificate# ______________________________

Group/Plan # ______________________________

Subscriber's Name ______________________________

PRESCRIPTION (REQUIRED FOR WAIVER APPROVAL)

Prescription Processor ______________________________
(example: Medco, Caremark, Express)

Member # ______________________________

Subscriber's Name ______________________________

Rx Group # (RxGRP) ______________________________

Rx Bin # (RxBin) ______________________________

(Circle One)

Y ☐ **N** ☐ I will be covered through 8/31/2011.

If 'no,' please indicate date of termination: ______________________

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

______________________________ ____________
Student Signature Date

Return Medical Insurance Waiver Form to:

NYU School of Medicine ● Office of Student Affairs ● 550 First Avenue, SLH ● New York, NY 10016 ● Fax: 212.263.0520