Student Health Insurance Waiver Form

Academic Year 2016-2017

INSTRUCTIONS: In order for your waiver to be reviewed, you will also need to submit a copy of the back and front of your health insurance card.

A. PLEASE INDICATE YOUR INFORMATION

Last name: First name: Social security number:

Date of birth: Gender:

Home address:

City: State/Prov.: ZIP/Postal code:

Country:

Primary phone number:

Email:

B. PLEASE INDICATE YOUR ENROLLMENT STATUS FOR THE 2016-2017 ACADEMIC YEAR (CHECK ONE)

- ☐ Full-Time Student (9 credits or more)
- ☐ Part-Time Student (less than 9 credits)
- ☐ Exempt Status Student (please specify): _____
- ☐ Not Full-Time Student BUT Residing in JTS Housing
- ☐ Barnard Student
- ☐ Other (please specify): _____

C. PLEASE INDICATE WHICH TYPE OF COVERAGE YOU ARE CHOOSING

By signing the Student Health Insurance Waiver Form you are choosing to waive out of the Gold/Platinum of the Columbia Insurance Plan for the entire academic year unless in the case of a qualifying event. By signing the Student Health Insurance Waiver Form you are also asserting that you have comparable coverage which meets ALL of the following criteria:

1. My plan provides coverage for all medically necessary* care while I am in New York City or traveling in the United States or abroad. Alternate plans must provide routine and urgent care for both inpatient and outpatient medical and mental health services. A policy that provides only emergency or urgent care does not meet this requirement.
   * Please refer to the detailed Health Insurance Plan Design and Benefits Summary on Aetna Student Health's website for a definition of medically necessary.
2. The policy year maximum benefit for my coverage is at least $300,000 per condition with no per incident maximums.
3. My coverage will remain in force as long as I am a registered student including approved leave of absence for medical reasons and non-degree status at The Jewish Theological Seminary.
4. My coverage is effective on August 15, 2015 (January 1, 2016 for new Spring enrollees) through August 14, 2016 and will cover me for any pre-existing conditions.
5. My plan covers all of the following types of care: treatment for injuries resulting from the practice or play of athletics, inpatient and outpatient psychiatric care, and treatment for chemical dependency.
6. My plan is licensed to do business in the United States and has a U.S. based claims office and a U.S. telephone number so local hospitals and providers can contact your carrier to discuss your care and bill directly. Foreign state government plans do NOT meet this requirement.

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D. INFORMATION OF COMPARABLE PLAN (PLEASE ATTACH A COPY OF THE BACK AND FRONT OF YOUR HEALTH INSURANCE CARD)

Name of policy holder:

Policy number:

Name of health insurance carrier:

Address:

City: State: ZIP code:

Phone number:

E. PLEASE ACKNOWLEDGE YOUR UNDERSTANDING

I have read the description of coverage provided to students at The Jewish Theological Seminary. I have also read the waiver criteria, and certify that the above insurance is comparable coverage. **I understand that all full-time and residential students as defined on p.1 of this document will automatically be enrolled and charged for the Columbia Health fee even though I am completing this document.** Furthermore, I understand that I am legally responsible for any medical expenses incurred during my enrollment at JTS. (Parent/Guardian should sign if student is under the age of 18).

Signature of Student or Parent/Guardian: Date: