

## OHSU Student Health Insurance Waiver Policy

Fall term 2009 through Summer term 2010

**The OHSU mandatory student health insurance policy can be waived under certain circumstances.** Your request to waive coverage from the OHSU/ODS Student Insurance plan must show that your current insurance plan, for which a waiver is sought, meets the basic health coverage features of the university plan, i.e. to be approved it must be a plan open to all members of a group regardless of individual circumstances, *including past medical history, race, ethnicity, gender, etc.* And it must insure adequately against unanticipated medical costs at a minimum of one million dollars lifetime benefit. **Please Note:** Under this waiver policy you have the option of waiving out of one or more as long as the waiver criteria are met. For example: you can waive out of medical, keeping dental; or you can waive out of dental and keep medical. **Please Note:** You cannot enroll in any portion of the plan if your program did not elect to carry that portion of the plan: For example: If your program elected to carry only medical, you cannot enroll in dental.

Evidence of the following would satisfy the University's waiver criteria:

- Employer group coverage with a minimum lifetime benefit of no less than \$1,000,000.00, where the insured is a spouse or a parent of the student, or the student's own employer group plan when the student is employed. (Employer group insurance is open to all in the group regardless of personal circumstances. Individual policies require a rating process of the individual before acceptance as a policy holder; therefore your rates are indicative of your health status. Group plans do not have this rating process)
- Coverage under Medicare, Medicaid, FHIAP, OMIP, or coverage under a Cobra plan that extends employer group coverage.
- A unique individual plan providing a minimum of \$1,000,000.00 lifetime benefit that meets extenuating circumstances such as the following: The student has a permanent ongoing medical condition and as such would not qualify for insurance for that condition after leaving OHSU after being enrolled in the required student group insurance. Therefore is requesting a waiver to keep a plan which is guaranteed renewable, permanently as long as the premium is paid, but would be irrevocably lost if terminated to enroll in the OHSU student plan. An individual plan qualifying under this third criterion must have no other contingencies other than payment of premium for guaranteed renewal. Applications for exemption of individual plans based upon this extenuating circumstance criterion must provide sufficient information for verification.

These criteria are subject to change on an annual basis, and changes will be announced to new and continuing students in the month of May each year. **DEADLINES:** All applications for waivers must be received in the OHSU Student Health Service office *before* the first day of the month in which a student's FALL term starts; and must be reapplied for annually. Applications which **DO NOT** include the required documentation as indicated on the waiver application form will not be considered. *Applications received on or after the first day of the month, if approved, will not be effective until the beginning of the next month.*

## Student Group Health Insurance Waiver Application and Affidavit

**Deadline:** Applications must be received in the Student Health Service office before the first day of the month in which your FALL term starts. If you are a new student applications must be received in the Student Health Service office before the first day of the month in which your Program starts. Annual re-applications are due before the first day of the month in which fall term begins.

### Fall, Winter, Spring, Summer Terms 2009-2010

If Approved This Waiver Expires at the end of Summer Term, 2010

Student Name: \_\_\_\_\_

SS#: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Email address for notification: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Date of application: \_\_\_\_\_

OHSU degree or certificate program: \_\_\_\_\_

Campus Location: \_\_\_\_\_

Training start date: \_\_\_\_\_; Expected Date of Graduation: \_\_\_\_\_

#### For Official Use Only

Contact: \_\_\_\_\_

S. S.: \_\_\_\_\_

ISIS Off: \_\_\_\_\_

Term: \_\_\_\_\_

Enroll: \_\_\_\_\_

ISIS on: \_\_\_\_\_

Completed by: \_\_\_\_\_

Date Completed: \_\_\_\_\_

### Major Medical Insurance—Required for Students of All Programs

I hereby request to decline enrollment into the mandatory OHSU/ODS student group health insurance in favor of continuing my current alternative health insurance plan. If this waiver is approved, I certify that I will maintain this insurance and if it is terminated will notify **Student Health Services** no less than 30 days of such termination. I am requesting this waiver on the basis of one of the following three choices. (Check one):

- I. Employer group coverage with a minimum lifetime benefit of not less than \$1,000,000.00, where the insured is a spouse or a parent of the student, or the student's own employer group plan when the student is employed.

#### Required documentation:

*Attach schedule of benefits showing lifetime maximum benefit of at least \$1,000,000.00. Attach a copy of your insurance card.*

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Group policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of employer: \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

Your relationship to primary insured: \_\_\_\_\_

- II. Coverage under Medicare, Medicaid, FHIAP, OMIP, Veterans Affairs, Tricare/Military or coverage under a Cobra plan that extends employer group coverage.

**Required documentation:**

If enrolled in a private insurance plan (one of the above programs) list the following:

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

**DO NOT FORGET TO: Attach proof of current eligibility and enrollment in one of the above covered programs.**

- III. Coverage under an individual health insurance plan already in effect for at least a year or more, providing a minimum of \$1,000,000.00 lifetime benefit where there are extenuating circumstances such as the following: the student with a permanent ongoing medical condition who would not qualify for insurance for that condition after graduating and terminating the required OHSU/ODS student group insurance, is requesting a waiver to keep a plan already held for more than one year and prior to the onset of such medical condition, which is guaranteed renewable permanently if not terminated, but would be irrevocably lost if terminated to enroll in the OHSU/ODS student plan.

**Required documentation:**

Name of insurance company: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_

Phone number of insurance company: \_\_\_\_\_

Date of inception of this policy: \_\_\_\_\_

Policy number: \_\_\_\_\_ ID# \_\_\_\_\_

Name of employer: \_\_\_\_\_

Name of primary insured: \_\_\_\_\_ DOB \_\_\_\_\_

Your relationship to primary insured: \_\_\_\_\_

- Attach a **statement from the insurance company** stating the current policy is guaranteed renewable on a permanent basis with no exceptions, except non-payment of premium.
- Attach **schedule of benefits** showing lifetime maximum benefit of at least \$1,000,000.00.
- Attach on a separate piece of paper a **signed narrative** explaining your extenuating circumstances.

**Dental Insurance – Required for all Programs *except* PharmD and the School of Dentistry.**

*I hereby certify that I will maintain employer group dental insurance with the following company:*

Name of Primary Insured: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB \_\_\_\_\_ Group Policy# \_\_\_\_\_ ID# \_\_\_\_\_

Insurance Company: \_\_\_\_\_

- I understand that this application will not be considered without appropriate documentation, and that I am subject to sanctions up to and including permanent dismissal from OHSU for intentionally providing misinformation in this document.
- I understand that if this waiver is approved, it will expire at the start of the next Fall term, 2009, and I must re-apply before it expires if I wish to continue this exemption from the required student insurance.
- I understand that the insurance premium for the entire term will appear on my tuition account and it may take two weeks or longer to have refunds credited after the waiver application is approved.
- I understand that if I lose this waived insurance during the school year I must, within 30 days, enroll in the OHSU student group plan or be approved for a new waiver for a different qualifying plan.
- I affirm that the statements in this affidavit are true to the best of my knowledge:

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip code

**Address:** OHSU Student Health Service, Mail Code: L587  
3181 SW Sam Jackson Park Road, Portland, OR 97239  
**Phone:** (503) 494-8665 **FAX:** (503) 494-2958 **Email:** askshs@ohsu.edu