Oregon Health & Science University
Insurance Verification Form 2013/2014

Copies of Insurance policies are not acceptable.

Oregon Health & Science University requires all full-time students to maintain comparable **group** health insurance. Students may satisfy the insurance requirements through group sponsored plans, parent sponsored self employed plans (until age 26), Medicare, Medicaid, Tricare, FHIAP or OMIP that meets certain minimum criteria or through enrollment in a group insurance plan. Please refer to the OHSU brochure which is available to view online at www.aetnastudenthealth.com

Section I

Student Name: Last: ______________________ First: ______________________ Date of Birth:____________

Student Contact Number: __________________ Student ID: _____________________

Student Email Address: ____

Postdoctoral Scholar With The Postdoctoral Health Plan ☐YES
Only Complete Section I & sign

Student Address: _____________________________City:______________ State:____________ Zip:______

Section II

Name of Insurance Company: ____

Subscriber Name: ____

Member ID Number: _________________________________Country:____________

Insurance Company/Group Policy # ______________________Insurance Co Telephone #_____________________

Insurance Effective Date: _____________________ Insurance Expiration Date: ____________________

I hereby attest that this plan meets the following standards (enter Y or N on the line next to the statement):

- I am insured on a group sponsored plan as the primary member or as a dependant. ____________

- I am under age 26 AND insured on my parents plan which is a Self Employed Plan: _____

- This plan offers an annual maximum of at least $1,000,000 AND no internal limits on specific conditions/treatments. ______

- This plan is not medically underwritten and provides open enrollment into the plan without regard to medical history, race, ethnicity, gender etc. (excluding PARENTAL self employed plans). ______

-This plan has a Prescription Benefit Program. ______

- This coverage will remain in force throughout the 2013 - 2014 academic year. ______

- This plan has inpatient and outpatient medical and behavioral health care in the state of Oregon. ________

- IMPORTANT NOTE - If approved, I acknowledge the need to meet the University set waiver deadlines and if missed, I understand the waiver will be applied to the next 2013 – 2014 academic term. Please see www.ohsu.edu/jbt-health for additional details about waiver deadlines.
- I understand that if this waiver is approved, it will expire at the end of Summer Term 2014 and I must re-apply before it expires if I wish to continue this exemption from the required medical insurance.
- I understand that the insurance premium for the entire term will appear on my tuition account and it may take up to two weeks or longer to have refunds credited after the waiver application is approved.

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REQUIRED: Student Signature
NOTE; Please include a copy of the FRONT AND BACK of your current insurance card along with this form

Please Return To:
Attn: OHSU Insurance Waiver Appeal
Email: askjbthealth@ohsu.edu
Fax: (503) 494-2958
Questions??
-Email askjbthealth@ohsu.edu or Call (503)494-8665