

# MEDICAL INSURANCE WAIVER FORM: 2009-2010

Use this form to request a credit of the default medical insurance fee. Please print clearly. Email is sent to the student's campus email account when a waiver is approved. Questions? Visit [www.studentaffairs.cmu.edu/healthservices/insurance](http://www.studentaffairs.cmu.edu/healthservices/insurance), email [shinsure@andrew.cmu.edu](mailto:shinsure@andrew.cmu.edu), or call 412 268 2157 and select the option for insurance.



This form must be completed by the deadline of your first semester on campus each enrollment year. Deadlines are as follows:  
Fall semester, September 3, 2009; Spring semester, Jan 31, 2010; Summer semester, June 15, 2010

## STUDENT INFORMATION

<i>Student's Last Name</i>	<i>First Name</i>	<i>MI</i>	<i>Date of Birth (mm/dd/yyyy)</i>
<i>9-digit Carnegie Mellon Student Account # (This is your SS#, or a 9-digit number starting with 999 or 700.)</i>	<i>Email address</i>	<i>Phone #</i>	
Campus Status: <input type="checkbox"/> Full-time student: <input type="checkbox"/> Part-time student:	Complete the entire form. A blank field may result in a denied waiver. Complete only the STUDENT INFORMATION section. Your fee will be waived.		

## INSURANCE COMPANY INFORMATION

<i>Insurance company name</i>	<i>Insurance company phone #</i>
<i>Insurance company's address</i>	

## INSURANCE POLICY DETAILS

Student is listed on the policy as the: <input type="checkbox"/> Principal Subscriber <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent	
If student is not the principal subscriber, provide the name of the individual who is the policy holder: _____	
<i>Student's Insurance Policy/Group #</i>	<i>Student's Insurance Member ID #</i>
What organization provides this insurance? <input type="checkbox"/> The <b>policy holder's employer/university</b> provides the plan. Identify employer/university: _____ <input type="checkbox"/> The <b>self-employed policy holder</b> provides the plan. <b>Include a letter</b> on official company letterhead from the policy-holder verifying his/her self-employment, and the company's name, address, and phone number. <input type="checkbox"/> The <b>student's government provides this plan to all citizens</b> . Identify the country: _____ The government's mandated plan must be the plan that meets the five requirements below. Students are not permitted to self-purchase additional insurance to meet those conditions. <input type="checkbox"/> The <b>student's government subsidized this plan</b> . This means that participants can enroll only if they meet certain criteria (low income level or handicapped status, for example). <input type="checkbox"/> The <b>student's sponsoring organization</b> provides this plan. Identify the organization: _____ <b>Include a letter</b> from the sponsoring organization verifying your insurance is part of the program's sponsored package. Sponsoring organizations must be formal government-affiliated programs. <input type="checkbox"/> The <b>retired policy holder</b> purchased this plan. Students obtaining a degree are not considered to be retired. <input type="checkbox"/> This plan is not provided by one of the above approved sources. We cannot approve this waiver.	

## INSURANCE REQUIREMENTS: You must be able to answer Yes to all six conditions listed below.

- Yes  No Offers at least 75% coverage for emergency, inpatient and outpatient medical services
- Yes  No Has a deductible that does not exceed \$500 per accident or illness
- Yes  No Offers medical benefits of at least \$50,000 per accident or illness
- Yes  No Includes mental health benefits
- Yes  No Does not contain any clause limiting/excluding coverage on a pre-existing condition
- Yes  No Covers the above 5 conditions in the city where I am enrolled for Carnegie Mellon classes

## INSURANCE EXPIRATION DATE:

This insurance  will be effective or renewed through July 31, 2010; or  
 will expire on \_\_\_\_\_ If I am still a full-time degree seeking student at the time my insurance  
Date (mm/dd/yyyy) expires, I will enroll in Carnegie Mellon's contracted medical insurance  
plan. I will complete my enrollment prior to this expiration date.

**CERTIFICATION OF WAIVER:** The information I've presented here is true, and Carnegie Mellon may contact my insurance company for verification. I will resubmit this form if my insurance changes in any way. I realize that, once waived, I can enroll in the student insurance plan only if I lose my private insurance involuntarily, or cancel it during the alternative plan's open enrollment period.

\_\_\_\_\_  
Signature (if student is under 18, parent must sign)

\_\_\_\_\_  
Date (mm/dd/yyyy)

**RETURN THIS FORM TO:** Student Health Services, Carnegie Mellon, 1060 Morewood Ave, Pittsburgh, PA 15213 FAX: 412 268 6357