

EASTERN NAZARENE COLLEGE

2021-2022 International Student Health Insurance Waiver Form

Please complete this form in its entirety and return to moneill@univhealthplans.com. Waivers will be reviewed within 10-15 business days. Notification of waiver acceptance/denial will be sent to the Eastern Nazarene College Office of Student Accounts and your Eastern Nazarene College email address. If you have any questions, please contact University Health Plans directly at 833-251-1729.

(Please note that the waiver deadline dates are the same for International Students as they are for Domestic Students. Please refer to the main page at www.universityhealthplans.com, select the link for Eastern Nazarene College for the applicable waiver deadline dates).

IMPORTANT: If you are an International student or other non-U.S. resident, and you are eligible to waive THE ENC plan because you are covered by an Embassy Sponsored Program, or a U.S. based health insurance plan with equal or better coverage, you may complete and submit this international student waiver form. Please note that International insurance plans and travel insurance plans such as ISO, Tokio Marine, International Medical Group, and Global Benefit Group, as well as any insurance plan or company marketed as "international" or "travel" are not acceptable, and you are ineligible to submit this form.

Please answer the following questions by circling yes or no.

1. I understand I am waiving coverage for the entire academic year through August 14, 2022, and will not be able to enroll in the Eastern Nazarene College Student Health Insurance Plan mid-year. I understand that if I lose my private health insurance coverage while I am an active student at Eastern Nazarene College and want to enroll in the school plan, I must submit an insurance enrollment form through University Health Plans within 60 days from the date I lose my previous coverage.

Yes / No

2. I have reviewed both my plan and the Eastern Nazarene College plan and have determined my current coverage to be comparable to the Eastern Nazarene College Student Health Insurance Plan.

Yes / No

3. My health insurance plan has local participating hospitals, physicians, pharmacies and mental health care providers reasonably near Eastern Nazarene College.

Yes / No

4. My plan provides coverage for out-patient care and provides access to local doctors, specialists, hospitals and other health care providers in emergency and non-emergency situations in the Eastern Nazarene College area. (If your plan is an out-of-area HMO, then it does not provide comparable coverage and you cannot answer yes)

Yes / No

5. My health insurance plan is a Health Safety Net Plan, MassHealth Limited, or Children's Medical Security.

Yes / No

6. I acknowledge by waiving the Student Health Insurance Plan, I am solely responsible for any medical expenses I may incur and neither Eastern Nazarene College nor the Insurance Company will be held responsible for any medical expenses.

Yes / No

7. My insurance company is headquartered outside of the United States.

Yes / No

8. Does your current plan fully comply with the Affordable Care Act?

Yes / No

Please fill in the below information about yourself and the plan you are covered under.

First Name: _____

Last Name: _____

Student ID: _____

Eastern Nazarene College Email Address: _____

Insurance Company Name: _____

Group Number: _____

Type of Insurance: _____

Insurance Address: _____

Insurance City: _____

Insurance State: _____

Insurance Country: _____

Insurance Zip: _____

Insurance Phone: _____

Subscriber Name: _____

Subscriber ID Number: _____

Subscriber Relation: _____

Person Completing the Waiver Form and your Relation to Student: _____

STATEMENTS OF ACKNOWLEDGEMENT:

By completing this waiver form, I am attesting to the following:

- By waiving the school-sponsored Student Health Insurance Plan, I acknowledge that it is my responsibility to maintain adequate private health insurance throughout the entire academic year, and it is not the responsibility of Eastern Nazarene College.
- I acknowledge that I am responsible for payment of all fees for medical and mental health treatment not covered by my private health insurance plan including but not limited to deductibles, copays, coinsurance and expenses above my policy maximums and benefit limits.
- If I participate in any sport, I understand that my private insurance plan needs to provide coverage for me to be seen **in the area reasonably nearby the ENC campus** for all treatment related to an injury including emergency services, surgery, follow up appointments and physical therapy if needed.
- I understand that some health facilities may require payment at the time treatment is provided.
- I have compared coverage of my private insurance and the ENC sponsored Student Health Insurance Plan and have determined that my private insurance meets or exceeds the coverage of the ENC sponsored Student Health Insurance Plan.
- I understand that my waiver may be reviewed and that my waiver may be denied if, during the review, my insurance company indicates that my coverage does not meet or exceed the ENC sponsored Student Health Insurance Plan.
- I understand that if my waiver is denied at any time, I will automatically be enrolled in and billed for the Student Health Insurance Plan.

I certify that all of the above "Statements of Acknowledgment" are true.

YES _____

NO _____

Please sign below:

Student or Parent's Signature

Date