ITHACA COLLEGE

2021-2022 International Student Health Insurance Late Waiver Appeal Form

Please complete this form in its entirety and return to moneill@univhealthplans.com. Late Waiver Appeals will be reviewed within 2 weeks of receipt. Notification of late waiver appeal acceptance/denial will be sent to Ithaca College and your student email address. If you have any questions, please contact University Health Plans directly at 800-437-6448.

Please provide the reason for missing the posted Ithaca College waiver deadline date:

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_____

_____

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_____

Section 1:

Please answer the following questions by circling yes or no.

1. I understand I am waiving coverage for the entire academic year through August 9, 2022, and will not be able to enroll in the Ithaca 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 Ithaca College and want to enroll in the school plan, I must submit an insurance enrollment form through University Health Plans within 31 days from the date I lose my previous coverage.

   Yes / No

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

   Yes / No

3. My health insurance plan has local participating hospitals, physicians, pharmacies and mental health care providers within a 50 mile radius of Ithaca 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 Ithaca College area. (If you plan is an out-of-area HMO, then it does not provide comparable coverage and you cannot answer yes)

   Yes / No

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

   Yes / No

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

   Yes / No

Section 2:

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

First Name:_____

Last Name:_____

Student ID:_____

Ithaca 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:_____

_____

I certify that the coverage under this health plan is comparable to coverage under the student health insurance program and I understand I am responsible for my medical expenses once this waiver is submitted. I also certify that my insurance coverage will remain in effect without restrictions providing coverage during the academic year 2021-2022. The submission of this waiver form including all information herewith constitutes truthful and accurate statements. If inaccurate information is submitted, the student will be enrolled immediately into the student health insurance plan offered through Ithaca College and will be responsible for the applicable charge. The student will lose the eligibility to waive the student health insurance plan for the duration of their enrollment in a degree-granting program. The student will automatically be enrolled into the student health insurance plan offered by Ithaca College unless documented proof of current enrollment in a comparable health insurance plan is provided each year while attending Ithaca College.

Please sign below:

_____ _____

Student or Parent's Signature **Date**