BOSTON UNIVERSITY

CELOP Summer 2009
Medical Insurance Waiver

Students should compare the benefits, limitations, and exclusions of their alternate health insurance plan with those provided by the Boston University Student Medical Insurance plan before filing their Medical Insurance Waiver. For a detailed description of the student medical insurance plan benefits limitations, and exclusions, and for instructions how to use the plan, visit Aetna Student Health's website (www.aetnastudenthealth.com), Click on "Find Your School", enter "Boston University" as "Your School Name". The insurance benefits for Summer 2009 are described n the 2008//2009 policy year brochure.

NOTE: Summer 2009 Medical Insurance Waiver Forms must be submitted NO LATER than the end of first week of the student's Summer CELOP course.

STUDENT NAME: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

last name *first name*

BU ID NUMBER : |__|__|__| - |__|__| - |__|__|__|__|

Insurance company name: _____

Insurance company (claims) address: _____

_____ **Telephone number (customer service):** _____

Policy Number / Member id*: _____ **Group Number (if applicable):** _____

**(The policy or other number used to identify the student's participation in the health insurance plan listed above)*

Name of Primary Card Holder (subscriber): _____

Your Relationship to Card Holder (subscriber): ☐ **self** ☐ **parent/guardian** ☐ **spouse**

Card Holder's (subscriber) address:_____

NOTE: (The student may list any additional health insurance policies that cover the student on the reverse side of this firm)

READ SECTION BELOW CAREFULLY AND SIGN:

- **I certify that my health insurance plan which I have listed on this waiver form will provide me throughout the school year with reasonably comprehensive coverage of health services, including preventive and primary care, emergency services, surgical services, hospitalization benefits, ambulatory patient services, and mental health services.**
- **I certify that these services provided by my health insurance plan are reasonably accessible to me in the area where I am attending school. I understand that a health insurance plan that covers only emergency services where I am studying is not comparable coverage and does NOT qualify for a waiver.**
- **I certify that I have compared my health insurance plan to the Boston University Student Medical Insurance Plan and I have determined the benefits to be at least comparable.**
- **I understand that I will be responsible for all medical insurance expenses incurred by myself/son/daughter and neither Boston University nor its student medical insurance plan will be responsible.**
- **I attest that no claims have been submitted for payment under the Boston University student medical insurance plan for the 2008/2009 policy year.**

All students (and parents/guardians) signing the waiver form: **I certify the above information is true and accurate.**

_____ _____

Student Signature and Date Parent/Guardian Signature and Date***

**** If the student is below age 18, this form must be co-signed by the parent or guardian*

Please return this form to: Boston University Student Accounting Services, 881 Commonwealth Avenue, lower level, Boston, MA 02215, or fax the completed form to Student Accounting Services at 617-353-3313