BOSTON UNIVERSITY

SUMMER 2024 STUDENT INSURANCE WAIVER FORM

For International Students and new CELOP Students

If you are a new Summer student and are would like to be considered for a waiver of the Summer Student Health Insurance Charge:

- *Provide your alternate insurance information on this form.*
- *Your alternate insurance coverage must be based in the United States. Waivers cannot be accepted for insurance plans that are not U.S.-based.*
- *Travel insurance cannot be accepted to waive the Student Health Insurance.*
- *Please complete and return this form along with a copy of the front and back of your insurance card to: Boston University Student Accounting Services, 25 Buick Street, Suite 130, Boston, MA 02215, by email to insmed@bu.edu or by fax to 617-353-3313.*
- *If you are not eligible for a waiver of the insurance charge, an email notification will be sent to your BU email address.*

For a description of the BU Student Health Insurance Plan (SHIP), visit Aetna Student Health's website (www.aetnastudenthealth.com/bu), Refer to the 2023-2024 Plan Year documents.

STUDENT NAME: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

last name   first name

BU ID NUMBER : |___|___|___| - |___|___| - |___|___|___|___| COL: |___|___|___| BU email address: ____________________

Please complete the information below. Items marked with"" must be completed.. Please contact your insurance provider if you need assistance with any of the responses.*

* Name of Insurance Company: ____

* Health insurance Plan is Underwritten in the United States? ☐ Yes ☐ No

* Health insurance Plan is ACA Compliant? ☐ Yes ☐ No

* Insurance plan name: ____

* Type of Insurance (circle one): PPO / EPO / POS / VA / Medicaid / Indemnity / Medicare / Military / Open Access

* Policy Number / Member id (for student): ________________________ Group Number (if applicable): ______________

Policy Expiration Date:_____/_____/_______

Deductible: ________________________ Co-Insurance: ________________________

Insurance company (claims) address:

Insurance company Street: ____________________________________

Insurance company City: ____________________________________

* Insurance company State: ________ Insurance company Zipcode: ____

* Insurance CompanyTelephone number (customer service): ________________

* Policy Holder First Name (subscriber): ________________________

* Policy Holder Last Name (subscriber): ________________________

* Policy Holder Date of Birth (subscriber): _____/_____/_______

* Student Relationship to Policy Holder (subscriber) : ☐ self ☐ child ☐ spouse

Employer: ____

By waiving the Student Health Insurance Plan, I confirm that I am currently enrolled in the Health Insurance Plan listed above and the coverage will continue for the full Summer Session. I have reviewed the Comparable Coverage Checklist and found my health plan meets all elements. I have also compared my health insurance plan listed to BU SHIP and determined the coverage to be comparable. I understand that I will be solely responsible for any medical expenses that I may incur and neither Boston University nor its student health insurance plan will be held responsible for any medical expenses. I attest that no claims have been submitted for payment under the Boston University Student Health Insurance Plan for Summer 2024. My signature certifies that the above information is true and accurate.

By submitting this form, I understand that I am granting permission for this waiver form to be audited. If the information provided on this form is determined to be incorrect or invalid, I understand that I will be enrolled in the Student Health Insurance Plan and charged the full insurance premium.

________________________________   ________________________________

Student Signature and Date   Parent/Guardian Signature and Date*

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