

SUMMER 2023 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 <u>insmed@bu.edu</u> 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 2022-2023 Plan Year documents.

STUDENT NAME: Image: Imag
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) :
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 both plans and determined my current 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 2023. 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

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