

HEALTH INSURANCE WAIVER PROCEDURES

- Health insurance waivers are for health insurance only. All students are required to maintain the Emergency Assistance & Evacuation insurance each semester.
- Approved fall semester waivers will be applied for both fall and spring semesters of the current academic year only. Additional academic years require submission of updated waivers. You must notify Insurance Coordinator if any changes to your current policy during the academic year.
- If you are an employee of the University (Graduate Assistant/Teaching Assistant/Lecturer), you do not need to submit a waiver application **EXCEPT** if you opt out the employee insurance.
- **Travel insurance** is not the same as health insurance and will not be accepted.
- All tuition and other charges including Int'l Health & Emergency and Evacuation insurance must be paid before it's due to avoid late payment fee.

INSTRUCTIONS:

STEP 1	Review your current policy. Benefits must meet minimum qualifications listed on Verification of Insurance Policy Benefit Form attached.
STEP 2	Complete International Health Insurance Waiver Form attached.
STEP 3	Send Verification of Insurance Policy Benefits to your insurance company for completion.
STEP 4	Signatures required on all forms. Send completed forms before the deadline: Oct 15 th (fall) or Feb 15 th (Spring) to: insurancewaivers@albany.edu
STEP 5	All signed forms must be scanned on PDF format and send in as original copy. Picture format taken from smartphone cannot be accepted.
STEP 6	Wait. Review of applications begins August 15 th . Please allow 3-4 weeks for processing.

IF WAIVER IS APPROVED: The Insurance Coordinator will remove your health insurance charges and you will receive a refund for this amount.

IF WAIVER IS DENIED: You will receive an email notification from the Health Insurance Coordinator for explanation of denial. Payment for the health insurance will be required. Any additional late payment fees will be your responsibility.

NOTE: Insurance Waiver application received but incomplete will not be processed.

Student Signatures _____ Date (MM/DD/YYYY) _____



INSURANCE WAIVER APPLICATION

TERM(s): FALL _____ SPRING _____ SUMMER _____ Academic YR _____ to _____

Health Insurance waiver application must be completed prior to October 15th for fall students and February 15th for new students starting for the spring Semester.

PLEASE COMPLETE THE FOLLOWING STUDENT INFORMATION:

STUDENT NAME: _____

First

Middle/Initial

Last

UALBANY ID (000 or 001): _____ - _____ - _____ GENDER: Male Female VISA TYPE: _____

DATE OF BIRTH (MM/DD/YYYY) _____ Home Country: _____

UALBANY EMAIL: _____ PHONE: _____

LOCAL ADDRESS: _____

CITY, STATE, ZIP CODE _____

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

INSURANCE COMPANY PHONE NUMBER: _____

INSURANCE Policy or Certificate Number Issued To You: _____

EFFECTIVE DATE OF YOUR INSURANCE (MM/DD/YYYY): _____

TERMINATION DATE OF YOUR INSURANCE (MM/DD/YYYY): _____

I certify that my current health insurance coverage meets or exceeds the above listed minimum coverage. I understand that the sole purpose of SUNY's review of this information is to determine if I qualify for a waiver of enrollment in the Student Health Insurance Plan. I understand that SUNY's review and/or approval of this application does not constitute a determination by SUNY as to the adequacy of this coverage for any purpose. I certify that my health insurance coverage is in effect and will remain in effect for the entire coverage period for which I am requesting this waiver. I certify that I am legally responsible for my own medical expenses and that SUNY is not responsible for such expenses and fully agree to hold harmless the "University".

Student Signature _____

Date _____

VERIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgment at the bottom of the form and return completed form to your campus representative.

Student Name: _____ School ID #: _____
Last Name First Name MI

NAME OF INSURANCE COMPANY _____

All monetary units must be expressed both in the relevant foreign currency and in U.S. dollars at the current exchange rate.

Effective dates of coverage: ____/____/____ through ____/____/____

1. Annual Maximum Benefit per Injury or Sickness Foreign: _____ USD: _____
\$400,000 minimum required to obtain waiver

2. Deductible amount Foreign: _____ USD: _____

3. Maximum daily benefit for In-hospital room & board Foreign: _____ USD: _____

4. Is Medical Evacuation covered? Yes _____ No _____
To what amount? Foreign: _____ USD: _____

5. Is Repatriation covered? Yes _____ No _____
To what amount? Foreign: _____ USD: _____

6. Are Outpatient Emotional and Mental Disorders covered? Yes _____ No _____
Required to obtain waiver-minimum 30 visits
To what amount? Foreign: _____ USD: _____

7. Are Inpatient Emotional and Mental Disorders covered? Yes _____ No _____
Required to obtain waiver-minimum 30 visits
To what amount? Foreign: _____ USD: _____

8. Is Outpatient Alcoholism and Substance Abuse covered? Yes _____ No _____
Required to obtain waiver
To what amount? Foreign: _____ USD: _____

9. Are Prescription Drugs covered? Yes _____ No _____
Required to obtain waiver
To what amount? Foreign: _____ USD: _____

VERIFICATION OF INSURANCE POLICY BENEFITS

10. Are Pre-Existing Conditions covered? Yes _____ No _____
Required to obtain waiver

Is there a Waiting Period - Number of Months: _____

Has it been met? Yes _____ No _____

11. Suicide/Self-Inflicted Injuries covered? Yes _____ No _____
Required to obtain waiver

12. Doctor Office Visits at 100%? Yes _____ No _____

13. Plan will pay providers directly for doctor
Office visits and inpatient services Yes _____ No _____
Required to obtain waiver

_____/_____/_____
Representative Name (PRINT) Representative Signature Phone Number Date

I take full responsibility for the answers I have supplied above, and fully agree to hold harmless (College/University Name) for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give permission for enrollment and benefit information to be released to _____ for the purpose of attempting an insurance waiver and to file for statistical use and use of the participant for medical reasons.

_____/_____/_____
Policy Holder's Signature Date Policy Holder's Email Address

Per the State University of New York, all of the above requirements must be met in order to obtain a successful waiver. Upon completion, please submit all the signed forms by **October 15th** for Fall semester and **February 15th** for new students starting for Spring semester.