UofA Student Health Insurance Exemption Request

1. Please circle who your coverage is being provided through and complete form

- Government/Official Sponsor- Name____(complete entire form)
  If sponsor is on the "List of Approved Sponsors" disregard this form, you will be auto-exempt
- UofA/ASU/NAU Employer- Provide a copy of your health insurance enrollment and this form (skip 2-13 and complete 14)
  Go to UAccess Employee Self Service & select "Benefits", "Benefits Summary" than "Medical".
- US Employer- Name____(complete entire form)
- New US Employer- Name____(complete entire form)
- Exchange Program- Name of Home University/Organization____
  Form must be filled out and signed by home university or organization coordinating your exchange (not the UA).
- Thesis, Research, Dissertation or Distance Learner - Provide documentation and this form (skip 2-13 and complete 14)
- Defending – Provide documentation and this form (skip 2 – 13 and complete 14)
- Transfer Student (Summer Only) - Provide documentation and this form (skip 2-13 and complete 14)
- Winter session or Summer pre-session course - Provide documentation and this form (skip 2-13 and complete 14)

Official Representative must complete numbers 2 – 13

2. Is this a Group Health Insurance policy? Yes No
3. Can the registered UofA student cancel this policy? Yes No
4. When did coverage take effect for this student? ____________________________
5. Is there a benefits open enrollment period? Yes No If yes, when does new coverage take effect?_______________

6. Name of Insurance Company:____Phone Number:_________________________
   Policy/Group Number:____Member ID Number:____________________

7. What is the maximum benefit **per** injury or sickness under this policy?____

8. Is there an annual individual deductible under this policy? Yes No In-Network Deductible: ___________

9. Does the subscriber have a coinsurance responsibility under this policy? Yes No In-Network Coinsurance: _______%

10. Does this policy provide coverage for the following?

Preexisting Conditions	Yes	No	Inpatient Hospitalization	Yes	No
Outpatient Surgery	Yes	No	Primary Care Services	Yes	No
Specialty Care Services	Yes	No	Maternity Coverage	Yes	No

11. Is this student provided a Repatriation Benefit? Yes No Amount: ________________
12. Is this student provided a Medical Evacuation Benefit? Yes No Amount: ________________

13. **<u>English Version of Benefits Summary Page</u>** along with this completed form can be emailed, faxed or mailed to:

Campus Health Service
Student Insurance
P.O. Box 210095
Tucson, Arizona 85721-0095

Office Phone (520) 621-5002
Fax number (520) 626-8616
Email: chsinsurance@health.arizona.edu

____
Printed Name of Official Representative Title Date

____
Contact Phone Number Email Address Fax Number

14. I understand that if I lose coverage, change insurance companies or my benefits change under my plan, I must notify the Campus Health Insurance Office within 30 days. Failure to do so will forfeit my right to be considered for any future exemption requests. I also understand that dependent upon my benefits open enrollment, I will be asked to provide updated documentation.

____
Student Name (please print) Student ID Number Date Requested Semester

____
Email Address Phone Number