BOSTON UNIVERSITY

STUDENT HEALTH INSURANCE WAIVER

2018/19 ACADEMIC YEAR

This waiver form is for students charged for the Boston University Student Health Insurance Plan in the Fall 2018 semester. The Fall 2018 waiver deadline is August 6, 2018. Please return the completed form to: Boston University Student Accounting Services, 881 Commonwealth Avenue, lower level, Boston, MA 02215, by email to insmed@bu.edu or by fax to 617-353-3313.

Think Before You Waive: ***View the Student Health Insurance Guide and determine if the student will have comparable coverage at: http://www.bu.edu/shs/ship/ and review the checklist under Waiving SHIP.***

Many health insurance plans offer limited or no coverage if you are out of network. Please contact your current insurance provider and be sure that your plan will cover you for preventive care, primary care, mental health care, hospital care and surgical care as well as prescription drug coverage where the student is studying.

Review Your Health Insurance Decision Guide at http://www.bu.edu/shs/ship/ to determine if waiving the Boston University Student Health Insurance Plan is in your best interest.

STUDENT NAME: GUPTA (last name) AJAI (first name)

BU ID NUMBER : U52-45-1913 **COLLEGE**: ENG

Insurance company name: United Health Care

Insurance plan name: (80840) 911-87726-04 Choice Plus

Insurance company (claims) address: PO Box 30555, Salt Lake City UT 84130-0555

Telephone number (customer service): 877-842-3210

Policy Number / Member id (for student): 963741182 **Group Number (if applicable):** 700406

Name of Primary Card Holder (subscriber): AJAI GUPTA

Card Holder's (subscriber) relationship to student: ☐ **self** ☑ **parent/guardian** ☐ **spouse**

Card Holder's (subscriber) address: 1400 Kring Way, Los Altos CA 94024

☑ I certify that the health insurance plan that I have listed on this waiver form is now in force and will be maintained for the remainder of the 2018/2019 academic year.

☑ I certify that the health insurance company that I have listed on this waiver form is a U.S. based health insurance carrier (unless Ithe student is studying outside of the U.S.)

☑ I certify that the plan listed above does not have an annual nor lifetime dollar limit on coverage.

☑ I certify that the plan is not: a product with a closed network of providers accessible only for emergency coverage where the student is studying. Examples of these include out-of-area HMO, EPO, and Medicaid plans.

☑ I certify that the plan meets the Minimum Creditable Coverage (MCC) standards of Massachusetts. Information regarding MCC standards can be found at www.mahealthconnector.org/minimum-creditable-coverage. Examples of plans that do not meet MCC standards include: Health Safety Net, MassHealth Limited and the Children's Medical Security Program.

By submitting this form, I certify that I have compared my health insurance plan to the Boston University Student Health 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 me, including deductibles, copays, and charges that may be billed by Boston University Student Health Services, and neither Boston University nor its Student Health Insurance Plan will be responsible. I attest that no claims have been submitted for payment under the Boston University Student Health Insurance Plan for the 2017-2018 policy year. My signature certifies that the above information is true and accurate.

Student Signature and Date

Parent/Guardian 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*