



Calvin University Student Health Insurance Waiver Form

Name: _____ Calvin ID: _____

Calvin University requires that all undergraduate students enrolled in at least 6 credit hours carry medical insurance. If you are covered by other medical insurance and wish to waive the coverage offered by United HealthCare, your insurance coverage must meet the criteria listed below. If you are uncertain about your insurance benefit plan, contact your insurance carrier to confirm the coverage limits. Please note: **Calvin University requires International students to enroll in the student health plan.**

1. My plan provides major medical coverage, including hospital care, physician care, and medications, and meets the Affordable Care Act requirements. **YES NO**
2. My plan provides coverage for the academic year, and I intend to remain enrolled in this plan for the entire academic year. **YES NO**
3. My insurance carrier is a company based in the United States, and hospitals and doctors will be able to bill them directly. **YES NO**

THE FOLLOWING INFORMATION IS FOUND ON YOUR INSURANCE CARD:

Insurance Company Name _____

Insurance Claim Address _____

Contract/Policy/Member ID # _____ Group # _____

Policy Holder Name _____ Policy Holder Date of Birth _____
(Policy Holder is the person who is financially responsible for payment of charges)

Policy Holder's Relationship to Student: _____

Policy Holder's Address _____

By submitting this form, I acknowledge that: **1)** I am currently covered by the above-mentioned plan; **2)** My plan is NOT a travel or a plan that expires when I've been in the US for a limited number of days less than the number of days in the semester; **3)** I have verified my coverage is accepted in the Grand Rapids area by contacting my insurance carrier, or I have adequate financial resources available to pay for the co-payments or other charges such as deductibles that may be related to out of network limitations; **4)** I understand that if I lose my medical insurance at any time during the academic year, I must either *a)* immediately secure other coverage and notify Health Services of this alternative coverage or *b)* elect to enroll in the student health plan and pay the applicable premium. **5)** I am aware that Health Services bills all carriers except Medicaid, Medicare, Champus and Tricare; **6)** I am aware that Health Services only participates with Blue Cross Blue Shield, Blue Care Network, Priority Health, Cofinity, Aetna, ASR, Cigna and United HealthCare. The charges from services rendered at Calvin Health Services are determined by my insurance plan and may be further reduced if Dr. Laura Champion is listed as my Primary Care Physician.

Signature of Student

Date