Calvin College Student Health Insurance Waiver Form

Name: __________________________________________ Calvin ID: __________________________

Calvin College 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 College 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

4. My insurance carrier is not a Medicaid plan, or if it is a Medicaid plan, it is provided by the State of Michigan. (Medicaid plans that are provided by any other state will not satisfy this criteria.)  
   YES   NO

THE FOLLOWING INFORMATION MAY BE FOUND ON YOUR INSURANCE CARD:

Insurance Company Name ____________________________

Company Address ______________________________________

Contract/Policy/Member ID # ________________________ Group # ________________

Policy Holder Name ____________________ Policy Holder Date of Birth ____________
   (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, 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