Edward Waters College

Health Insurance Waiver Form

Edward Waters College requires all full-time students to have health insurance coverage. The EWC, Florida Blue Student Medical Insurance Plan offers insurance coverage to students. If you have other coverage that is comparable to the guidelines below and wish to waive out of the EWC 2014 Fall student insurance, this form must be submitted by the waiver deadline: Athletes and Band Members/August 31, 2014 and Non-Athletes/September 23, 2014. If the waiver form is not submitted, the student insurance premium will be added to your tuition bill.

This form is required to be filled out in order to receive a health insurance waiver.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print name) do hereby certify that I currently have at least the minimum health insurance coverage benefits listed below and required by the School.

1. Coverage Period: Coverage must include the full academic year, including annual breaks, regardless of the student’s terms of enrollment. The policy must provide continuous coverage for the entire period the insured is enrolled as an eligible student. Payment of benefits must be renewable.

2. Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and outpatient customary fees must be paid at 80% or more of usual and customary, reasonable charge per accident or illness for in-network, and at least 50% or more of usual, customary and reasonable charge for out-of-network providers per accident or illness.

3. Inpatient Mental Health Care: Must be paid at 80% in-network or 50% out of network of the usual and customary fees with a minimum 30 day cap per benefit period.

4. Outpatient Mental Health Care: Must be paid at 80% in-network or 50% out-of-network of usual and customary fees for a minimum of 30 outpatient visits per benefit period.

5. Maternity Benefits: Must be treated as any other medical condition and paid at no less than 80% of usual and customary fees in-network or 50% out-of-network.

6. Inpatient/Outpatient Prescription Medication: Prescription Coverage

7. Exclusion for Pre-Existing Conditions: First six months of policy period, at most.

8. Deductible: Maximum of $100 per benefit period.

9. Maximum benefits paid (per benefit period): at least $500,000.

Insurance Company or Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify the information submitted is complete and accurate to the best of my knowledge. I understand that I am required to maintain health insurance for the full academic year. In the event termination or pertinent changes occur to my coverage, I will notify Collegiate Risk Management immediately.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Id# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach a copy of your insurance card and benefit page and submit this form to:

Health Services Office