

**UC Hastings College of the Law, Student Health Services
HEALTH INSURANCE WAIVER 2009-2010**

NAME _____ **Birthdate** _____ **Student ID#** _____

Address _____

Email _____ **Phone** _____

Check all that apply

Program / Status: JD ___ LL.M ___ EXCHANGE ___ INTERNATIONAL ___ VISITOR ___ **YEAR:** 1L ___ 2L ___ 3L ___

Reason for waiving the insurance _____

ALL HASTINGS STUDENTS pay the Student Health Services fee and may use the medical and counseling services through the Student Health Office. In addition, Hastings students are charged the Hastings Student Accident and Sickness Insurance premium as part of registration. You may review the current school insurance plan at <http://www.uchastings.edu/insurance>. If you wish to waive out of the Hastings insurance, you must show proof that you have another health insurance policy that meets the following requirements:

- A policy with a U.S. owned and operated insurance company meeting the requirements outlined in Section 2.
- An insurance card with YOUR name on it AND a front and back photocopy of the card, OR a Letter of Certification from the insurance company as verification of enrollment in the plan and submission of this information with the waiver form. Contact your insurance company for the letter. This is a common request that they can accommodate.
- Complete Sections 1, 2 and 4 of this form.

INTERNATIONAL STUDENTS who have insurance through a foreign country must, in addition to the above,:

- Provide the name, address, and phone number of a U.S affiliate office that will process and pay claims in U.S. dollars.
- Attach a letter (in English) from your health insurance company that verifies the dates of your coverage and outlines a summary of your benefits.
- Complete Sections 1, 2, 3, and 4 of this form.

DEADLINE INFORMATION. This completed waiver form **AND card copy or letter must be submitted to Student Health Services no later than Monday, January 25, 2010 by 2:00 pm.** If your waiver request is accepted, the charges for the Hastings insurance will be reversed. If you do not apply for a waiver by the deadline, you will automatically be enrolled in the Hastings Health Insurance and must pay the fee.

1. Name of Insurance Company _____

Address _____

Phone _____ **Policy Number** _____

2. Insurance Requirements – Please List Your Coverage Amounts Here

Type of Benefit	Your Plan's Benefit	Hastings Requirements
Lifetime Maximum per condition	U.S. \$	Minimum of \$50,000
*Annual Deductible	U.S. \$	*Maximum allowed is \$2,500
Primary Care in SF Bay Area	Yes or No (circle one)	Required
Emergency Care in SF Bay Area	Yes or No (circle one)	Required
Pharmacy/Prescriptions	Yes or No (circle one)	Recommended
Worldwide Coverage	Yes or No (circle one)	Recommended

*The annual deductible is what you pay directly for medical care before insurance coverage can begin. Your insurance company can give you this dollar amount if you have a deductible as part of your plan. If your deductible is higher than \$2500.00, you need to contact your insurance company to lower it to \$2500.00 or less by the deadline in order for your waiver request to be accepted.

3. Additional Requirements for INTERNATIONAL STUDENTS - Please List Your Coverage Amounts Here

Type of Benefit	Your Plan's Benefit	Hastings Requirements
Medical Evacuation	U.S. \$	\$10,000
Repatriation of Remains	U.S. \$	\$10,000

4. AGREEMENT: I understand and agree that if I waive out of the health insurance offered by Hastings College, I will maintain health insurance that meets the minimum requirements while I am enrolled as a student at Hastings. I understand that I must complete a waiver form for each academic year. I understand and agree that if my health insurance is terminated, I will file a waiver reversal request with Student Health Services during the next open enrollment period or purchase interim insurance. Finally, by signing this waiver form I acknowledge full responsibility for all medical and prescription costs associated with an illness or accident that occurs while I am enrolled as a student at Hastings.

Student Signature: _____ Date _____

RETURN BY FAX OR MAIL TO: Student Health Services, UC Hastings College of the Law
200 McAllister St./Suite 202/ San Francisco, CA 94102

Phone: 415.565.4612 Fax: 415.565.4607