International Student Request for Student Health Insurance Plan Waiver Exemption

2015-2016 Policy Year

All international students attending Boston College are required to enroll in the Student Health Insurance Plan sponsored by the College. The Student Health Insurance Plan is underwritten by Blue Cross Blue Shield of Massachusetts and is fully compliant with the provisions of the U.S. Department of Health & Human Services Patient Protection Affordable Care Act (PPACA) and also exceeds J-1 Visa requirements.

If you are insured through a parent/guardian’s health insurance plan offered through a U.S. employer, or a government sponsored program, (for example, Government of Kuwait/UAE or Government of Saudi Arabia) with coverage that meets or exceeds the Student Health Insurance Plan, you must fill out this form and return it to Gallagher Student Health & Special Risk for their review and determination.

Form Submission Deadline:
The deadline for the Fall Semester is September 25, 2015 and for students newly enrolled at the College beginning with the Spring Semester, the deadline is January 29, 2016.

A decision will be made concerning your request for health insurance waiver exemption within ten (10) business days. If your waiver exemption request is denied, you will remain enrolled in the plan offered by Boston College and you will be responsible for paying the insurance premium. You will be notified of the decision via your BC email account. In the event of an approval, Student Financial Services will remove the Student Health Insurance Plan premium for the approved term indicated in the decision letter.

I acknowledge that by submitting this form, I am requesting a waiver exemption to the Boston College Student Health Insurance Plan. In addition, I hereby certify that:

1. I am currently enrolled in a health insurance plan that will be in effect August 7, 2015 – August 6, 2016.
2. My current policy provides unlimited coverage, without an annual or lifetime maximum benefit.
3. My current policy provides comprehensive coverage of health services, including primary care, emergency services, surgical services, maternity coverage, hospitalization benefits, ambulatory patient services, and mental health services, and that these services are reasonably accessible to me in the area where I am attending school.
4. My current policy provides coverage for lab work, diagnostic x-rays, physical therapy, chiropractic care, and prescription coverage in the area where I attend school.
5. My current insurance plan provides unlimited benefits for medical evacuation and repatriation of remains.
6. My current insurance plan provides coverage for the following services in the Boston College area:
   - Doctors, specialists, hospitals and other health care providers
   - Inpatient and outpatient hospitalization
   - Inpatient and outpatient counseling and mental health services
   - Lab work, diagnostic x-rays, physical therapy and chiropractic care
   - Emergency room treatment and ambulance services
   - Maternity care
   - Prescription drugs

I am granting Gallagher Student Health & Special Risk, on behalf of Boston College, permission to verify this information. If it is determined that the information provided on this form is invalid, I understand that I will be enrolled into and billed for the Student Health Insurance Plan for that term and for future, subsequent terms.
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→PLEASE PRINT LEGIBLY←

_____________________________       _____/_____/_____
Eagle ID number                 Today’s Date
___________________________________________________________________  _____/_____/_____
Student’s Last/Family Name   First   MI       Date of Birth
____________________________________________________________________________________________________
Address    Apt. #    City   State  ZIP
BC Email (required)_________________________________________________ Telephone(_____)___-_______
________________________________________________________________________________________
College or School

I certify that I will have health insurance under one of the following throughout the 2015-2016 academic year:

☐ My health insurance is covered either through a U.S. employer, MassHealth (except by Health Safety Net, Children’s Medical Security or MassHealth Limited) or a plan purchased through the MA Health Connector.


NOTE: *No socialized/standard medicine policies, including Canadian policies, will be accepted.
*No travel insurance policies will be accepted.

Please attach a copy of the following two items with this request:

1. A copy of your current health insurance ID card or written verification of coverage.
2. A copy of your immigration papers. (I-20 for F-1 visas, DS-2019 for J-1 visas, etc.)
(Requests that are submitted without these two items may not be considered.)

Please allow 10 business days for processing. You will be notified of the decision via your BC email account.

Please keep a copy of this form (and any supporting documentation) for your records.

Student’s Signature _______________________________________ Date __________________

For more information and details about the Student Health Insurance Plan website:
www.gallagherstudent.com/BC

FOR OFFICE USE ONLY:
Rec’d_____/_____/_____   Approved ☐ for: Fall15 ☐ SP16 ☐   Denied ☐ By_______ Date_____/_____/_____
Student Notified. _____/_____/_____ Student Accounts Notified_____/_____/_____

Please return this form to: Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171 or scan applicable documents and email to, BCStudent@gallagherstudent.com