International Student Request for Student Health Insurance Plan Waiver Exemption

2016-2017 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.

International students who are insured through 1) a parent/guardian/spouse's health insurance plan offered through a U.S. employer, 2) a government sponsored program, (for example, Government of Kuwait/UAE or Government of Saudi Arabia) or 3) enrolled in Mass Health or a plan purchased through the MA Health Connector can complete this form and return it to Gallagher Student Health & Special Risk for their review and determination.

Please Note: International insurance plans, travel insurance plans, short-term medical plans and plans not fully-compliant with the Affordable Care Act are not acceptable and should not be submitted for considerations.

Form Submission Deadline:
The deadline for the Fall Semester is September 23, 2016 and for students newly enrolled at the College beginning with the Spring Semester, the deadline is January 27, 2017.

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 be advised of the approval and 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, 2016 – August 6, 2017.
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 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
6. I have coverage for unlimited benefits for medical evacuation and repatriation of remains services.

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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2016-2017 Policy Year

PLEASE PRINT LEGIBLY

Eagle ID number \____________-\____________-\_______/_____/_____

Student's Last/Family Name \__________________________ First MI Date of Birth \________/\_____/_____

Local 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 2016-2017 policy year.

☐ I am insured as a dependent (under parent/guardian/spouse's plan) by a health insurance plan offered through a U.S. employer
☐ I am enrolled in Mass Health (except by Health Safety Net, Children's Medical Security or Mass Health Limited) or a plan purchased through the MA Health Connector.
☐ My health insurance is offered by a non-US government sponsor. Examples: Government of Kuwait/UAE or Government of Saudi Arabia.

NOTE: Socialized/standard medicine policies, including Canadian policies, will not be accepted. International insurance plans, travel insurance plans, short-term medical plans and plans not fully-compliant with the Affordable Care Act will not 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

OR 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