UofA Student Health Insurance Exemption Request

1. **Please circle who your coverage is being provided through and complete form**

   - Government Sponsor- Name_____(complete entire form)
   - Official Sponsor- Name_____(complete entire form)
   - UofA Employer- Provide a copy of your health insurance enrollment and this form (skip 2-13 and complete 14)
     Employees- Go to your Employee Link and select "Total Rewards/Benefits" than "View Benefits".
     Dependents- Need to obtain documentation of enrollment from UofA Human Resources 520-621-3662
   - US Employer- Name_____(complete entire form)
   - Exchange Program- Name of Home University/Organization_____
     Form must be filled out and signed by home university or organization coordinating your exchange (not the UA).
     Your home university or organization must automatically provide insurance to you in order to be considered.
   - Distance Learner - Provide requested documentation and this form (skip 2-13 and complete 14)
   - Dissertation, Thesis or Research - Provide requested documentation and this form (skip 2-13 and complete 14)
   - Transfer Student (Summer Only) - Provide requested documentation and this form (skip 2-13 and complete 14)
   - Summer pre-session or Winter session course (skip 2-13 and complete 14)

Official Representative must complete numbers 2 – 13

2. Is this a Group Health Insurance policy? Yes No
3. Can the registered UofA student cancel this policy? Yes No
4. When did coverage take effect for this student? _____
5. Is there a benefits open enrollment period? Yes No If yes, when does new coverage take effect?_____
6. Name of Insurance Company:_____
   Policy/GroupNumber:_____
   Member ID Number:_____
   Phone Number:_____
7. What is the maximum benefit **per** injury or sickness under this policy?_____
8. Is there an annual individual deductible under this policy? Yes No Amount _____
9. Is there coinsurance under this policy? Yes No Percentage: In- Network _____ Out-of-Network _____
   In-Network Out-of-Network
10. Does this policy provide coverage for the following?

Preexisting Conditions	Yes	No	Inpatient Hospitalization	Yes	No
Outpatient Surgery	Yes	No	Primary Care Services	Yes	No
Specialty Care Services	Yes	No	Maternity Coverage	Yes	No

11. Is this student provided a Repatriation Benefit? Yes No Amount: _____
12. Is this student provided a Medical Evacuation Benefit? Yes No Amount: _____
13. **English Version of Benefits Summary Page** along with this completed form can be emailed, faxed or mailed to:

    Campus Health Service
    Student Insurance
    P.O. Box 210095
    Tucson, Arizona 85721-0095

    Office Phone (520) 621-5002
    Fax number (520) 626-8616
    Email: chsinsurance@health.arizona.edu

_____
Printed Name of Official Representative Title Date

_____
Contact Phone Number Email Address Fax Number

14. I understand that if I lose coverage, change insurance companies or my benefits change under my plan, I must notify the Campus Health Insurance Office within 30 days. I also understand that if I fail to contact the Campus Health Insurance Office within the 30-day period, I will forfeit my right to be considered for any future exemption requests.

_____
Student Name (please print) Student ID Number Date Requested Semester

_____
Email Address Phone Number