RHODE ISLAND SCHOOL OF DESIGN

2017-2018 Student Health Insurance Late Waiver Appeal Form

Please complete this form in its entirety and return to moneill@univhealthplans.com. Late Waiver Appeals will be reviewed within 7-10 business days. Notification of late waiver appeal acceptance/denial will be sent to the RISD Student Accounts office and your RISD email address. If you have any questions, please contact University Health Plans directly at 800-437-6448.

Please provide the reason for missing the posted RISD waiver deadline date:

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Private Insurance Information:

Please answer the following questions by circling yes or no.

1. I understand I am waiving coverage for the entire academic year through August 31, 2018, and will not be able to enroll in the RISD Health Plan mid-year. I understand that if I lose my private health insurance coverage while I am an active student at RISD and want to enroll in the school plan, I must submit an insurance enrollment form through Student Financial Services within 31 days from the date I lose my previous coverage.

   Yes / No

2. I have reviewed both my plan and the RISD plan and have determined my current coverage to be comparable to the RISD Student Health Insurance Plan.

   Yes / No

3. My health insurance plan has local participating hospitals, physicians, pharmacies and mental health care providers within a 50 mile radius of RISD.

   Yes / No

4. My plan provides coverage for out-patient care and provides access to local doctors, specialists, hospitals and other health care providers in emergency and non-emergency situations in the RISD area. (If you plan is an out-of-area HMO, then it does not provide comparable coverage and you cannot answer yes)

   Yes / No

5. I acknowledge by waiving the Student Health Insurance Plan, I am solely responsible for any medical expenses I may incur and neither RISD nor the Insurance Company will be held responsible for any medical expenses.

   Yes / No

6. My insurance company is headquartered outside of the United States.

   Yes / No

Please fill in the below information about yourself and the plan you are covered under.

First Name: _____

Last Name:_____

Student ID:_____

RISD Email Address:_____

Insurance Company Name:_____

Group Number:_____

Type of Insurance:_____

Insurance Address:_____

Insurance City:_____

Insurance State:_____

Insurance Country:_____

Insurance Zip:_____

Insurance Phone:_____

Subscriber Name:_____

Subscriber ID Number:_____

Subscriber Relation:_____

Person Completing the Late Waiver Appeal Form and your Relation to Student:

Completion of the Late Waiver Appeal form is not a guarantee that the appeal will be approved. The appeal process will determine if the circumstances for missing the posted waiver deadline date are valid and that the coverage you are waiving with is comparable to the plan offered by RISD. Please note that a waiver form must be completed for each Academic Year while attending RISD. In the event you miss future waiver deadline dates, we cannot guarantee that additional appeals will be approved.

I certify that the coverage under this health plan is comparable to coverage under the student health insurance program and I understand I am responsible for my medical expenses once this late waiver appeal is approved. I also certify that my insurance coverage will remain in effect without restrictions providing coverage in Rhode Island during the academic year 2017-2018. The submission of this waiver form including all information herewith constitutes truthful and accurate statements. If inaccurate information is submitted, the student will be enrolled immediately into the student health insurance plan offered through Rhode Island School of Design and will be responsible for the applicable charge. The student will lose the eligibility to waive the student health insurance plan for the duration of their enrollment in a degree-granting program. The student will automatically be enrolled into the student health insurance plan offered by RISD unless documented proof of current enrollment in a comparable health insurance plan is provided each year while attending RISD.

Please sign below:

_____

Student or Parent's Signature

_____

Printed Name

_____

Relation to Student

_____

Date