

UA Student Health Insurance Exemption Request



Student Must Complete This Section: Circle the category number that applies to you and follow the instructions. [Exemption Deadlines](#)

1. **Government/Official Sponsor** – Sponsor Name: _____ (both sections must be completed)
If you have an [approved sponsor](#) and have submitted your financial guarantee to International Student Services (ISS), please disregard this form. You will be automatically exempt.
2. **UA/ASU/NAU Employer** – Provide a copy of your “Benefits Summary” from [UAccess Employee](#): Select the “University Benefits” tile. If you are a dependent, you must provide a copy of the “Dependent/Beneficiaries Coverage Summary” page, available under “Your Dependents/Beneficiaries”. **For Spring Semester Only:** Submit after the close of the employee open enrollment and change the summary date to show a coverage effective date of January 1st. (complete student section only)
3. **US Employer** – Company Name: _____ (both sections must be completed)
4. **Exchange Program** – Name of Home University/Organization: _____
Home University or Organization coordinating your exchange must complete and sign form (not the UA or insurance carrier).
5. **Outside of the US** – Provide required attestation form mentioned under [Category 5](#). (complete student section only)
6. **Transfer Student (Summer Only)** – Provide proof of your student health insurance from another US university and this form. (complete student section only)
7. **Summer Pre-Session Course** – Provide proof of insurance and this form. (complete student section only)

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 of the event. Failure to do so will forfeit my right to be considered for future exemption requests. I also understand that dependent upon my benefits open enrollment, I will be asked to provide updated documentation.

For Fall Semester Requests Only: Check if you received an approved exemption for the previous Spring semester based on having coverage through a US employer **AND** your employer **has not** changed. In this case, complete the student section only and submit.

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|---|-----------------------------|---------------------|---------------------------|
| <i>Student Name (please print)</i> | <i>UA Student ID Number</i> | <i>Date</i> | <i>Semester Requested</i> |
| <i>Official UA Email Address (@arizona.edu)</i> | | <i>Phone Number</i> | |

Official Representative (ex. HR/Benefits Coordinator): All fields must be completed.

- Is Health Insurance coverage presently in effect for the above individual? Yes No
- If not, when will coverage take effect? _____
- When does the new policy year begin? _____
- Can this coverage be canceled by the individual? Yes No

*Does the individual have an HSA account? Yes No If yes, what is the individual deductible? _____

Important: If you have an individual deductible that exceeds \$1,000 and have an HSA account, your account balance must cover your deductible that exceeds \$1,000. A copy of your latest HSA end balance will be required.

- Is there a Medical Evacuation benefit provided to the above individual? Yes No If yes, benefit limit: USD _____
- Is there a Repatriation benefit provided to the above individual? Yes No If yes, benefit limit: USD _____

Important – Check all that apply. The health insurance policy provided **must meet all** health coverage guidelines below.

- Coverage is provided through a Group Health Insurance policy (*individual plans cannot be accepted, no exceptions*)
- The maximum benefit per injury or sickness under this policy is unlimited
- The annual individual deductible under this policy does not exceed \$1,000*
- The coinsurance responsibility for student does not exceed 50%

The policy provides coverage for all the following essential health benefits without exceptions or exclusions.

- | | | |
|--|--|---|
| <input type="checkbox"/> Ambulatory Patient Services | <input type="checkbox"/> Emergency Service | <input type="checkbox"/> Durable Medical Equipment/Prosthetic Devices |
| <input type="checkbox"/> Rehabilitative Therapy Services | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Maternity Coverage (entire pregnancy) |
| <input type="checkbox"/> Laboratory & X-ray Services | <input type="checkbox"/> Preventive Services | <input type="checkbox"/> Mental Health/Substance Abuse Services |
| <input type="checkbox"/> Coverage for Preexisting Conditions | <input type="checkbox"/> Prescription Drugs | |

Signature of Official Representative

Title

Date

Contact Phone Number

Email Address

Fax Number