Oregon State University
Student Health Services

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Graduate Fellow/Post-Doctoral Scholar/ Clinical Fellow Insurance Waiver Form

Last name **First name** **OSU ID Number**

Date of Birth
_____ / _____ / _____

Address: _____

_____

Gender: ☐ Male ☐ Female

Phone: _____ **Department:** _____ **Marital Status:** ☐ Single ☐ Married

My citizenship is:

- ☐ INT - International Student. I attend OSU on a student visa.
- ☐ DOM - Domestic Student. I am a citizen or legal resident of the United States (including green cards).

I am waiving the insurance plan offered to me as a:

- ☐ Graduate Fellow
- ☐ Post-Doctoral Scholar
- ☐ Clinical Fellow

Begin Waiver Effective: _____/_____/_____

This waiver application is a:

- ☐ New waiver application
- ☐ Renewal of a previously approved waiver
- ☐ Waive Medical/Vision & Enroll Dental
  - ☐ Enrollment form attached

I qualify for the waiver under the following category

- ☐ I am sponsored by my embassy.
  - I have attached a copy of my letter of sponsorship or Embassy card and a copy of my insurance card.
- ☐ I am covered with a private insurance plan as an individual, as a U.S. based employee, or as a dependent of a U.S. based employee; coverage must have adequate equivalent or better coverage that covers both emergent and non-emergent care. This coverage may not be waived to coverage obtained outside the United States.
  - I have attached a copy of my insurance card(s), summary of benefits showing the plan meets requirements shown on the back of this form, and proof of medical, dental and vision coverage.

By signing below I certify the following:

- I have read the waiver requirements on the back of this application and understand that I will be required to enroll in the university plan if my insurance does not meet these requirements.
- ***ALL STUDENTS: I understand it is my responsibility to submit a new waiver form or insurance enrollment form when this waiver ends or if my current insurance policy changes to a different insurance.***
- ***INTERNATIONAL STUDENTS: I understand my insurance coverage must remain in effect for myself and any family members in the U.S. as long as I am enrolled at OSU.***

_____ _____
Signature Date

FOR OFFICE USE ONLY:

Date Received & initials:	Waiver Approved yes / no	Waiver begin date:	Waiver end date:	
Deductible $	Out-of-Pocket Maximum $	Coinsurance / Copays	Dental	Vision
Insurance Carrier	Member ID Number	Notes:		

Waiver Requirements for
OSU Graduate Fellow/Post-Doctoral Scholar/Clinical Fellow Plan

Pursuant to the requirements stated in the Letter of Offer, Graduate Fellows, Post-Doctoral Scholars and Clinical Fellows are required to either enroll in the OSU Graduate Insurance Plan or submit a waiver application showing proof of comparable coverage. Comparable is defined as meeting or exceeding the following criteria:

Yearly deductible/Plan max/ Out of pocket max	$600 per person, $1,000 max family / no lifetime plan max $1,000 out of pocket max per person at Preferred Providers
Office Visits	90% @ Preferred Providers, subject to yearly deductible.
Outpatient Lab & X-ray	90% @ Preferred Providers, subject to yearly deductible.
Hospital Room& Board, Surgeon, Anesthesia	90% @ Preferred Providers, subject to yearly deductible.
Physical Therapy	90% @ Preferred Providers, subject to yearly deductible.
Mental Health & Substance Abuse	90% @ Preferred Providers, subject to yearly deductible.
Prescription Drugs	$15, $25, $ 35 co-pay for generic, preferred, and non-preferred drugs
Emergency Room	$50 co-pay then 90% @ Preferred Providers, subject to yearly deductible.
Pregnancy	90% @ Preferred Providers, subject to yearly deductible.
Vision	One Exam per year, hardware: glasses or contacts
Dental	$1,000/yr including exams, cleanings, x-rays, restorative, extractions, oral surgery, crowns, dentures

- International Students must show minimum $50,000 coverage for Repatriation of Remains and minimum $50,000 coverage for Medical Evacuation

A new waiver application must be submitted every fall term and/or after returning from a break in employment. Those appointed during terms other than fall term need to submit insurance documents within the first month of the start of the position. If you change from one policy to another during the year, you are required to submit a new waiver application for review the month it becomes effective.

NOTE: Those who do not submit a waiver during the Open Enrollment period or first month of the term for which their fellowship or scholar position begins will be held responsible for enrolling in the OSU Graduate PacificSource Insurance Plan and for authorizing payment of the premium.

DOCUMENTATION

Documentation of such coverage must include the insurance company's name and address, policy number, the name of the individual covered by the policy, the effective dates of the policy, a summary of benefits with any exclusions/limitations, the deductible and maximum amount of coverage per accident and illness in terms of cumulative benefits in English and U.S. dollars.

LENGTH OF ENROLLMENT/WAIVER ELECTION

Waivers of PacificSource coverage will be effective for one year at a time, until employment/fellowship ends or until the private insurance ends. The waivers of PacificSource coverage will remain in effect for all other eligible terms during the same academic year unless otherwise notified. Fellows/employees who initially waive the plan may qualify to enroll in the plan at a later date under special circumstances (Qualifying event such as loss of coverage). Please contact the insurance office for more details.

Questions? Contact: **Audrey Roberson - Graduate Insurance Coordinator**
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