Oregon State University

Student Health Services
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2018 – 19 Insurance Waiver Form: Postdoctoral Scholars and Clinical Fellows

EMPLOYEE INFORMATION

Name (Last, First)			OSU ID number
Street Address			Sex ☐ Male ☐ Female
City	State	Zip code	Date of Birth / /
Email Address	Phone number		Department

Citizenship
- ☐ **International** – I am in the United States on a visa
- ☐ **Domestic** – I am a U.S. citizen or legal resident of the United States (including green cards)

REASON FOR WAIVING COVERAGE

☐ **I am covered by an employer group insurance plan as a U.S. based employee, or dependent of a U.S. based employee.**
- This insurance plan must have equivalent or superior coverage to the plan being offered by the university that covers both emergent and non-emergent care. This coverage may not be waived to coverage obtained outside of the United States.
- *Employer group insurance does not include: Oregon Health Plan (Medicaid plans), Veteran's Administration program, Student Health plans, or plans purchased on the individual market*.
- I have attached a copy of my insurance card(s), summary of benefits, and proof of medical, dental, vision and pharmacy insurance coverage.

☐ **I am waiving medical/vision insurance and am enrolling in dental-only coverage (my enrollment form is attached)**
- I have medical and vision insurance that meets the requirements on the back of this form.
- I have attached a copy of my insurance card(s), summary of benefits, and proof of medical, vision and pharmacy insurance coverage.

SIGNATURE AND ACKNOWLEDGMENTS

By signing below I certify the following:
- I am voluntarily waiving coverage provided by OSU due to having a private insurance plan that meets all requirements outlined on the back of this form and understand that I will be required to enroll in, and authorize payment for, the university insurance plan if my plan does not meet requirements.
- **ALL applicants**: I understand I am required to submit a new waiver form each fall term open enrollment period, and/or notify the OSU Student Health Insurance Office if my insurance policy ends or changes.
- **International applicants**: I understand my insurance coverage, including medical evacuation and repatriation of remains, must remain in effect as long as I have an appointment at OSU.

_______________________________________ _______________
Signature Date

FOR OFFICE USE ONLY:

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

INSURANCE WAIVER REQUIREMENTS: POSTDOCTORAL SCHOLARS AND CLINICAL FELLOWS

Pursuant to the requirements stated in your letter of offer, Postdoctoral Scholars and Clinical Fellows are required to either enroll in the OSU Graduate Health Plan or submit a waiver application showing proof of comparable (equivalent or superior) coverage within 30 days of their position start date.

Yearly deductible/Plan max/ Out of pocket max	$100 deductible per person / no lifetime plan max $1,000 out-of-pocket max per person at Preferred Providers
Office Visits	90% @ Preferred Providers
Diagnostic Lab and Imaging	90% @ Preferred Providers
Hospital Services & Surgery	90% @ Preferred Providers
Physical Therapy	90% @ Preferred Providers
Mental Health & Chemical Dependency	90% @ Preferred Providers
Prescription Drugs	$15, $25, $ 35 co-pay for generic, preferred, and non-preferred drugs
Emergency Room	$50 co-pay then 90% @ Preferred Providers
Pregnancy/Maternity	90% @ Preferred Providers, subject to yearly deductible.
Vision	One eye exam per year & hardware: glasses or contacts
Dental	$50 deductible, $2,500/yr annual benefit maximum for coverage including exams, cleanings, x-rays, restorative, extractions, oral surgery, crowns and dentures

- International applicants must have a minimum of $50,000 coverage for Repatriation of Remains and minimum $50,000 coverage for Medical Evacuation coverage

A new waiver application must be submitted every fall term open enrollment period and/or after returning from a break in employment. 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.

Approved waivers are effective for one academic year at a time, until employment ends, or until the private insurance plan ends. Members who initially waive the insurance plan will only qualify to enroll in the OSU plan at a later date under special circumstances (qualifying life event such as loss of private insurance coverage), or during the fall term open enrollment period.

INSTRUCTIONS

Complete the front side of this form and attach supporting insurance documents for a complete application. Submit the completed application to the OSU Student Health Insurance Office in person, via email, or via fax. The Insurance Coordinator will notify you via email with a decision regarding your waiver application.

Documentation:
- Copy of insurance card(s)
- Summary of benefits for medical, dental, vision and pharmacy insurance including: deductible, annual benefit maximum, out-of-pocket maximum, copays and coinsurance in English and U.S dollars

Questions? Contact:
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