

SUMMER 2025 STUDENT INSURANCE WAIVER FORM For International Students and new CELOP Students

If you are a new Summer student and are would like to be considered for a waiver of the Summer Student Health Insurance Charge:

- Provide your alternate insurance information on this form.
- Your alternate insurance coverage must be based in the United States. Waivers cannot be accepted for insurance plans that are not U.S.based.
- Travel insurance cannot be accepted to waive the Student Health Insurance.
- Please complete and return this form along with a copy of the front and back of your insurance card to: Boston University Student Accounting Services, 25 Buick Street, Suite 130, Boston, MA 02215, by email to <u>insmed@bu.edu</u> or by fax to 617-353-3313.
- If you are not eligible for a waiver of the insurance charge, an email notification will be sent to your BU email address.

For a description of the BU Student Health Insurance Plan (SHIP), visit Aetna Student Health's website (www.aetnastudenthealth.com/bu), Refer to the 2024-2025 Plan Year documents.

UDENT NAME: _
ID NUMBER : BU email address:
ase complete the information below. Items marked with"*" must be completed Please contact your insurance provider if you need assistance with
y of the responses.
ame of Insurance Company:
ealth insurance Plan is Underwritten in the United States? \square Yes \square No
ealth insurance Plan is ACA Compliant? 🛛 Yes 🛛 No
isurance plan name:
ype of Insurance (circle one): PPO / EPO / POS / VA / Medicaid / Indemnity / Medicare / Military / Open Access
olicy Number / Member id (for student): Group Number (if applicable):
Dicy Expiration Date: // Deductible: Co-Insurance:
surance company (claims) address:
surance company Street:
nsurance company City:
surance company State: Insurance company Zipcode:
surance CompanyTelephone number (customer service):
olicy Holder First Name (subscriber):
olicy Holder Last Name (subscriber):
olicy Holder Date of Birth (subscriber): /
tudent Relationship to Policy Holder (subscriber) : Self Child Spouse
employer-based coverage, list Employer company name, if a visiting college-sponsored student health insurance plan, list home school, else leave bla
ployer / Home School:

By waiving the Student Health Insurance Plan, I confirm that I am currently enrolled in the Health Insurance Plan listed above and the coverage will continue for the full Summer Session. I have reviewed the Comparable Coverage Checklist and found my health plan meets all elements. I have also compared my health insurance plan listed to BU SHIP and determined the coverage to be comparable. I understand that I will be solely responsible for any medical expenses that I may incur and neither Boston University nor its student health insurance plan will be held responsible for any medical expenses. I attest that no claims have been submitted for payment under the Boston University Student Health Insurance Plan for Summer 2025. My signature certifies that the above information is true and accurate.

By submitting this form, I understand that I am granting permission for this waiver form to be audited. If the information provided on this form is determined to be incorrect or invalid, I understand that I will be enrolled in the Student Health Insurance Plan and charged the full insurance premium.

Student Signature and Date

Parent/Guardian Signature and Date*

*The student signature is required. If the student is below age 18, this form must be co-signed by the parent or guardian.