STUDENT MEDICAL PLAN WHILE ON CO-OP SPRING 2020

While on co-op assignment your tuition account is not automatically charged the Medical Plan fee. Please complete this form to join or decline enrollment in the Student Medical Plan.

_____ Yes I would like to be enrolled in the Student Medical Plan while on Co-Op I understand the fee of $1,165 will be placed on my tuition account. The period of coverage for spring semester 2020 is January 13, 2020 to July 31, 2020.

_____ I would like to decline participation in the Student Medical Plan because I already have health insurance coverage. I am currently insured with the following company ____________________________________________________________

My coverage meets the following waiver criteria listed below ___________ (initial here)

1. Insurance coverage is provided by a company licensed to do business in the United States, with a US claims payment office and telephone number.
2. Coverage is currently active and the student agrees to maintain health coverage throughout the entire policy year.
3. Offers unlimited coverage per accident or illness.
4. Offers inpatient and outpatient medical care in Northeast Ohio or where enrolled in CWRU classes. Emergency-only coverage does not satisfy this requirement.
5. Covers inpatient and outpatient mental health and alcohol abuse care within Northeast Ohio or where enrolled in CWRU classes. Emergency-only coverage does not satisfy this requirement.
6. Prescription medication is covered.
7. Does not contain any clause that limits coverage on pre-existing conditions.
8. International students coverage must provide emergency medical evacuation coverage in the amount of at least $50,000 (medical evacuation is emergency transportation to the nearest, most qualified treatment facility).
9. International students coverage must provide at least $25,000 coverage for Repatriation (repatriation provides transportation to the student's home country in the event of death).

Student’s Name: ________________________________________________________________

Student ID number: __________________________ Date: _____________________________

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE UNIVERSITY HEALTH SERVICE BY JANUARY 13, 2020 OR EMAIL MEDICALPLAN@CASE.EDU