US Employer Insurance Coverage/Exemption Request

Please fill out the following information on the insurance that is provided to your employee or dependent of employee.

1. Name of Insurance Carrier:______________________________

   Group # / Policy #:______________________________

   Member ID:______________________________

   Phone #:______________________________

When did coverage take effect for this University of Arizona student under this plan?______________
Is the University of Arizona student the employee or a dependent under this policy?______________
If a dependent under the plan, at what age would coverage end?______________
Does your Company provide a "Benefits Open Enrollment" period? Yes No
If yes, when does the new coverage take effect?______________

2. What is the maximum lifetime benefit under this policy?______________

3. Does this policy cover repatriation? Yes No Amount:______________

4. Does this policy cover emergency medical evacuation? Yes No Amount:______________

5. Does this policy provide the following coverage's?

Maternity	Yes	No
Prescription	Yes	No
Inpatient Hospitalization	Yes	No

6. Is there an annual deductible under this policy? Yes No Amount:__________ (In- Network) __________ (Out-of-Network)

7. Is there coinsurance under this policy? Yes No Percentage:__________ (In-Network) __________ (Out-of-Network)

8. Please either fax or mail the **Benefits Summary** page along with this completed form to:

   Campus Health Insurance
   The University of Arizona
   P.O. Box 210095
   Tucson, Arizona 85721-0095

   Office Number (520) 621-5002
   Fax Number (520) 626-8616

______________________ ______________________ ______________
Employer Contact Number Date

______________________ ______________________ ______________
Representative Signature Representative Name Printed Title

Once our office receives your completed form, we will notify you through your official university email address (@email.arizona.edu) within five business days to let you know if we can approve you for an exemption from the Student Health Insurance or not.

I understand that if I lose coverage under this plan, that I have 30 days from when this coverage ends to contact the Campus Health Insurance Office. I also understand that if I fail to contact the Campus Health Insurance Office within the 30-day period, I forfeit my right to be considered for an exemption from the university student health insurance in future semesters.

______________________ ______________________ ______________
Student Name Student ID Number Date

Please specify which semester you are requesting an exemption: ______________