



Cornell University
Office of Student
Health Insurance

Student Health Insurance Plan
Enrollment/Waiver Form
FALCON SUMMER PROGRAM, 2009

INSTRUCTIONS: Please fill out either the ENROLLMENT or WAIVER section of this form and return **no later than May 29, 2009** to:

FALCON Program
388 Rockefeller Hall
Ithaca, NY 14850

Questions about insurance?
Phone: 607.255.6363
E-mail: sicu@cornell.edu

Due to policy restrictions, students may not enroll in or cancel the SHIP after the program begins.

Name _____ Date of Birth _____ / _____ / _____ Gender Female Male
(Last, First - Please print clearly using ink) *(mm/dd/yy)*

E-mail Address _____ Cornell 7-digit Student I.D. # _____

Local Address _____

ENROLLMENT

Enroll me in the Student Health Insurance Plan. I will send the **\$378.50** payment for the premium (US Currency payable to Cornell University. **DO NOT SEND CASH.**) no later than May 29, 2009 to the address above. Coverage dates are June 3, 2009 to August 5, 2009. I understand that that **this policy is nonrefundable** if I leave the FALCON program early for any reason.

Student Signature _____ Date _____

WAIVER

I have health insurance that satisfies the conditions listed below, and I do not wish to purchase the Student Health Insurance Plan.

- You must indicate that your plan meets *each* of the conditions below by checking the "yes" boxes.
- If your coverage does not meet *all six* of these conditions, you may not waive. You must purchase the Student Health Insurance Plan.
- If you do not know whether your coverage meets these conditions, contact your health insurance plan administrator to get current, accurate information about your plan before completing this form.

| YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. My plan is provided by a company licensed to do business in the United States, with a US claim payment office and US phone number. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. My plan provides coverage in the Ithaca area for outpatient and inpatient medical care. (Coverage for emergency care only does <i>not</i> meet this requirement.) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. My plan provides coverage in the Ithaca area for outpatient and inpatient mental health care. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. The maximum benefit for my coverage is at least \$500,000 per year. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. My coverage will remain in force as long as I am a full-time registered student (including <i>in absentia</i> and non-degree status) at Cornell University. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. My plan provides coverage for pre-existing conditions. |

Insurance Company _____ *(including Medicaid/Medicare)*

Subscriber Name _____ Subscriber Birthdate _____ / _____ / _____

Subscriber's Relationship to Student _____ Insurance Policy # _____

Insurance Co. Address _____ Insurance Co. Phone # _____

NOTE: Cornell University reserves the right to verify insurance information. If your plan does not meet these requirements, or you are uninsured, you will automatically be charged for and enrolled in the Student Health Insurance Plan.

WAIVER PETITION SIGNATURE

By my signature, I affirm that I have health insurance coverage that meets *all six* of the conditions described above. I understand I am legally responsible for all medical expenses incurred during my enrollment at Cornell University and that the University will not be responsible for any medical expenses.

Signature _____ Date _____

All students are eligible to use Gannett Health Services, regardless of their insurance coverage.