



Cornell University
Office of Student
Health Insurance

Student Health Insurance Plan
Enrollment/Waiver Form
OUTDOOR ODYSSEY 2009

INSTRUCTIONS: Please fill out either the ENROLLMENT or WAIVER section of this form and return to:

Cornell Office of Student Health Insurance
409 College Avenue, Suite 211
Ithaca, NY 14850

Web: www.studentinsurance.cornell.edu
Phone: 607.255.6363
E-mail: sicu@cornell.edu

Name _____ Date of Birth / / 7-Digit Student I.D. # _____
(Last, First - Please print clearly using ink) (mm/dd/yy)

E-mail Address _____ Gender M F

Home Address _____

ENROLLMENT

Please enroll me in the Student Health Insurance Plan (SHIP), which will cover me for the length of my program. I will send the **\$126.17 payment** for the premium to the address above no later than **five days prior to the start date**. (Payment must be in **US dollars, check or money order only; no cash, no credit cards.**) I understand that **this policy is nonrefundable** if I leave the Wilderness Reflections Program for any reason.

Please check (✓) your program: July 5–11, 2009 August 14–21, 2009 August 16–21, 2009

Participants in the August 17–21 program may not enroll in or waive the SHIP using this form, as the 2009-10 SHIP Plan Year includes this time period.

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 for my week with Wilderness Reflections.

- 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 not 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 at Cornell University. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. My plan provides coverage for pre-existing conditions. |

Insurance Company _____ (incl. 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 _____