

Carnegie Mellon University Qatar

Office of Health and Wellness

Medical Insurance Waiver Form

Use this form to request a credit of the default medical insurance fee. Please print clearly. An email is sent to your andrew email account when a waiver is approved.

Failure to submit this form will result in automatic enrollment and your student account will be charged. You will not be able to waive the plan after **July 1** and will be responsible for the fee charged.

This form must be completed each enrollment year by the deadline of **July 1** and must be emailed to: health-wellness@qatar.cmu.edu

Student Information

Last Name	First Name	MI	Date of Birth (mm/dd/yyyy)
Carnegie Mellon Andrew I.D.			Gender
Email address	Phone #		Nationality

Insurance Policy Information - Complete the information below and provide a copy of your insurance card, front and back

Student is listed on the policy as the: <input type="checkbox"/> Principal Subscriber <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		
If student is not the principal subscriber, provide the name of the individual who is the policy holder: _____		
Insurance Company Name and, if applicable, employer name	Policy ID # and/or Group #	
Claims billing Address and/or claims billing phone number		
Student's Insurance Number	Policy Start Date	Policy End Date

Terms and Conditions for Waiving

Insurance Requirements: You must be able to answer **Yes** to all seven conditions listed below to qualify for a waiver

- Yes No Your insurance coverage must be continuing coverage that verifies enrollment as a dependent or primary card holder in an employer or government sponsored private insurance plan.
- Yes No Your policy must provide coverage for routine, urgent and emergent care for both inpatient & outpatient medical care and mental health coverage.
- Yes No Your policy must not contain any clauses limiting/excluding coverage based on pre-existing conditions.
- Yes No Your policy provides coverage in the State of Qatar with no less than \$ 100,000 per illness and \$ 100,000 per injury.
- Yes No It must provide Emergency Evacuation and Repatriation coverage

Insurance Expiration Date: This insurance will be effective or renewed through the current academic year, or will expire on _____
If I am still a full-time degree seeking student at the time my insurance expires, I will enroll in Carnegie Mellon's _____
contracted medical insurance plan. I will complete my enrollment prior to this date.

Certification of Waiver: The information I've presented here is true, and Carnegie Mellon may contact my insurance company for verification. I will resubmit this form if my insurance changes in any way.

*A summary of covered benefits from your current medical carrier should accompany this form to be considered for waiving the university offered health insurance.

Signature (if student is under 18, parent must sign)

Date (mm/dd/yyyy)

DO NOT COMPLETE - FOR OFFICE USE ONLY

Date Received (mm/dd/yyyy)

Processed by

Waiver Status Sent To Ins (mm/dd/yyyy)