STUDENT HEALTH INSURANCE ELECTION/WAIVER FORM 18-19

Soka University of America

All students at Soka University of America are required to have medical insurance coverage for urgent and emergency medical care within the locality of the SUA campus. This medical insurance may be provided through the University's student health plan or by another policy. Please complete the form and return it to Student Affairs. **If the student fails to turn in the completed form by the student will be automatically enrolled and the premium will be charged.**

☐ **I would like to enroll in SUA's insurance plan (All international students must enroll in SUA's plan)**
(Complete Part A, sign and return the form to Student Affairs)
Note: The annual premium for the Soka University of America's Student Health Plan is **$1836** (for each session, $918) and is underwritten by Anthem Blue Cross. This premium will be charged to your student account at the University.

☐ **I would like to waive SUA's insurance plan**
(Complete both Part A and Part B, attach a copy of both sides of the insurance card and return the form to Student Affairs)
Note: In order to waive the Student Health Plan your present coverage must meet the following criteria:
1. Your present policy must provide local urgent and emergency medical coverage while attending Soka University of America for the duration of student's enrollment. This is especially important if your plan is a managed care plan or health maintenance organization (HMO). Some plans will not pay for services provided "out of network". Please confirm this coverage with your current insurance provider.
2. Your present policy has unlimited medical benefit per injury or sickness.

PART A: STUDENT INFORMATION

Student's Name: Last_____ First_____ Soc. Sec. No. _____

Home Address: Street _____

City _____ State _____ Zip_____

Date of Birth ____/____/____ Phone Number (_____)_____

I understand that I am electing to enroll in the SUA Student Health Plan and the premium will be charged to my student account.

_____ _____
Student's Signature Date

PART B: MEDICAL INSURANCE INFORMATION (Attach a copy of BOTH SIDES of the insurance card)

Insurance Company _____ Policy Number _____

Insurance Co. Address _____ Group Number _____

Insurance Co. Phone _____ Expiration Date _____

I understand that to not enroll my son/daughter in the SUA Student Health Plan, I am certifying and attesting that (1) I have health insurance coverage for my son/daughter through the policy described above and the criteria as stated in the waiver statement, and; (2) this coverage will be in effect throughout the current academic year; and (3) I am responsible for medical expenses incurred during my son's/daughter's enrollment at SUA and; (4) if changes occur with the policy, SUA will be notified immediately of the new policy information, or; (5) if medical coverage ceases, I agree for my son/daughter to be enrolled in the SUA Student Health Plan and the student account will incur a charge from the effective date of coverage as dictated by SUA and Health Net policy and agreement.

_____ _____
Parent's or Guardian's Signature Date

FOR OFFICE USE ONLY	Date Received: