University of Wisconsin School of Medicine and Public Health

Fall 2015 Doctor of Physical Therapy Health Insurance Waiver Application

The University of Wisconsin School of Medicine and Public Health (SMPH) requires all students to be protected by health insurance that meets the pre-determined standards established by the School. **If you have active health insurance coverage that meets or exceeds ALL of the pre-determined requirements listed on page 2, you must submit this two-page Waiver Application by September 14, 2015, to inform us of this coverage in order to request an exemption from enrolling in the UW-Madison Student Health Insurance Plan (SHIP).**

**By September 14, 2015, do the following:**
1. Read and sign the Certification Statement below (page 1).
2. Complete and sign the Waiver Application (page 2).
3. Submit: A) page 1 and 2, and B) a copy of the front and back of your current health insurance ID card or written verification from your insurance provider, to: PT Program, 5173 MSC, 1300 University Ave., Madison WI 53706, or fax to 608-262-7809.

If you submit a Waiver Application after **September 14, 2015**, an administrative fee of $100 will be assessed.

In all cases, qualifying insurance coverage must have been in effect since August 15, 2015. If your qualifying insurance coverage has not been in effect since August 15, 2015, your Waiver Application will be denied and you will be required to purchase SHIP for the entire semester (August 15, 2015 through January 14, 2016). An administrative fee of $100 will also be assessed if the Waiver Application was submitted after September 14, 2013.

**Waiver Application Review:**
- You will be contacted if there are questions about your Waiver Application or if your Waiver Application is not approved.
- If your Application is approved, it will be subject to audit to verify the coverage meets the stated requirements. If the coverage is determined not to meet the requirements, you will be required to purchase SHIP for the entire semester (August 15, 2015 through January 14, 2016). An administrative fee of $100 will also be assessed if the deadline of September 14, 2015, has passed.

**Certification Statement: I acknowledge that by submitting this waiver application, I certify that:**
- My insurance plan meets or exceeds all of the Insurance Requirements listed on the Checklist on page 2 of this waiver application. I understand that if I have answered ‘No’ to any requirement/s I will need to submit an appeal to the Insurance Appeals Review Committee by September 1, 2015, and abide by their final determination.
- I understand that it is my responsibility to review the terms of coverage of my health insurance and to maintain continuous coverage.
- I understand that if it is determined that the information provided on this form is invalid or my qualifying insurance coverage has not been in effect since August 15, 2015, I will be required to purchase SHIP for the entire semester (August 15, 2015 through January 14, 2016). I understand that an administrative fee of $100 will also be assessed if the deadline of September 14, 2015, has passed.
- I understand that as long as my qualifying waiver is submitted by September 14, 2015, I will not be required to enroll in SHIP.
- I understand that if I submit a qualifying waiver after September 14, 2015, an administrative fee of $100 will be assessed.
- I have active health insurance coverage through August 14, 2016.
  Note: if your current plan ends during your waived period, see Loss of Insurance in the next bullet point below.
- I understand that if I experience a Loss of Insurance or a change of policy during the waived period I must enroll in SHIP or file another qualifying waiver within 31 days of the Loss of Insurance or an administrative fee of $100 will be assessed in addition to any required premiums.
- I will be solely responsible for all medical expenses, and neither the UW-Madison nor the SMPH will be held responsible for any medical expenses that I incur.
- I understand that information provided herein is confidential and will be used for the sole purpose of documenting my decision to waive and will not be made available to any third party.
- I understand that the SMPH reserves the right to conduct periodic reviews of waived insurance coverage.

____________________________________________________________   ___________________
DPT Student Signature of Understanding    Date

Direct questions to Physical Therapy Program at 608-263-7131
**DOCTOR OF PHYSICAL THERAPY STUDENT INFORMATION**

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<thead>
<tr>
<th>University ID (10 digits)</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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<tr>
<th>E-mail Address (@wisc.edu, please)</th>
<th>Birth Date (mm/dd/yyyy)</th>
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**INSURANCE REQUIREMENTS CHECKLIST**

**ANSWER YES OR NO FOR EACH CATEGORY**

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<th>Insurance Category</th>
<th>Coverage Requirement</th>
<th>Your Plan Meets or Improves on:</th>
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<td>Yes</td>
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- **Maximum Lifetime Benefit**: $1,000,000
- **Annual Plan Deductible**: $2,500 per person
- **Emergency Room (visits and treatment)**: 80% (after deductible/copayment)
- **Inpatient Hospital Benefits** (including labs, x-rays and miscellaneous expenses) *(Note: “limited medical benefit plans” with separate daily benefit caps on medical services such as intensive care are not acceptable)*: 80% (after deductible)
- **Outpatient Benefits** *(e.g. Physician office visits, labs, Physical Therapy, radiology etc.) in the location you will be studying (typically Madison)*: 80% (after deductible)
- **Mental Health Benefits** *(Inpatient, Outpatient and Chemical Dependency)*: Must include in-patient coverage

If you answer NO to a requirement and wish to appeal, attach a statement explaining your situation. Your Waiver Application and statement will be reviewed by the Insurance Appeals Review Committee and you will be informed of their decision. Appeals must be submitted to the PT Program by September 1, 2015.

**INSURANCE INFORMATION**

<table>
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<th>Name of Primary Member (if not you)</th>
<th>Your Relationship to Primary Member</th>
<th>Name of Insurance Company</th>
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Reminder: This Waiver Application cannot be reviewed unless it is accompanied by a copy of the front and back of your health insurance ID card and/or written verification of coverage. If you are a dependent and not the primary member, please ensure that your coverage details are included on the documentation. If you are unable to obtain the required documentation, please notify the PT Program, 608-263-7131, immediately.

**DOCTOR OF PHYSICAL THERAPY STUDENT SIGNATURE OF UNDERSTANDING**

X ____________________________________________________________________________

Doctor of Physical Therapy Student Signature __________________________ Date ____________

**THIS SECTION - FOR UWSMPH OFFICE USE ONLY**

Waiver □ Approved □ Denied □ Annual Waiver □ Fall Waiver □ Late Waiver

By: __________________________ Date: __________________________