



# DOMESTIC INSURANCE WAIVER FORM

2018-2019 Academic Year • OUAZ

**Student Name:** \_\_\_\_\_  
Last First Middle Initial

**OUAZ Student ID #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**A. I need to enroll in OUAZ sponsored primary health insurance plan!**  Yes  No

(If your answer is yes to statement A, we will enroll you in the OUAZ United Health Care insurance plan. You may skip questions 1 through 13 and sign, date, and return the form. If your answer is NO, complete the following 13 questions and then sign, date, and return the form.)

1. Do you have current and active health insurance? (I understand that my insurance company may be contacted to confirm coverage on a periodic basis.)  Yes  No
2. Does your insurance provide coverage through the current semester?  Yes  No
3. Does your insurance provide coverage for the entire academic year?  Yes  No
4. I certify that I have a medical insurance plan in place and acknowledge that I am responsible for payment of all fees for medical and mental health treatment not covered by my health insurance plan.  Yes  No
5. Does your plan comply with all applicable ACA requirements; and therefore, your plan is also not a short term medical policy? (Unlimited lifetime maximum, coverage for essential health benefits, and coverage for pre-existing conditions)  Yes  No
6. I can confirm my deductible does not exceed more than \$2000 In-Network, per person, per plan year.  Yes  No
7. My plan provides benefits for outpatient medical (including primary-care and specialist office visits), outpatient mental health, pharmacy, and ancillary services. Coverage for emergency-only care does not satisfy this requirement.  Yes  No
8. My plan has local participating hospital facilities, physicians, pharmacies, medical equipment vendors, and mental health care providers within a 50-mile radius of 85374 and/or provides out-of-network coverage for such services.  Yes  No
9. My plan is underwritten by a company licensed to do business (or domiciled) in Arizona.  Yes  No
10. The claims administrator for my plan is based in the United States and has a US telephone number and address for the submission of claims.  Yes  No
11. My plan is administered by an insurance company with a licensed claims office in the United States, and this claims office has a toll-free telephone line for claims inquiries.  Yes  No
12. Is your current coverage a policy other than Medicare or Medicaid?  Yes  No
13. My current health insurance plan provides coverage for intercollegiate sports injuries and therefore does not exclude intercollegiate sports.  Yes  No

**STUDENT SIGNATURE**

\_\_\_\_\_  
Student Signature Date