WAIVER OF SCHOOL OF MEDICINE STUDENT HEALTH PROGRAM (medical insurance)

Johns Hopkins School of Medicine requires all learners to have adequate medical insurance. If you elect to waive enrollment in the Student Health Program, we require that the alternative medical coverage meet all of the minimum criteria listed.

DEMOGRAPHIC INFORMATION OF STUDENT OR TRAINEE *(Please print)*

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL**: _____
DATE OF BIRTH (mm/dd/yyyy): _____ **REQUESTED EFFECTIVE DATE FOR THIS WAIVER (mm/dd/yyyy)**:_____

STATUS (CHECK ONE OF THE FOLLOWING)

☐ I am a medical student. I understand that I must pay the University Health Services fee regardless of enrollment or waiver of the Student Health Program medical insurance. I am requesting to opt out of the Student Health Program (SHP) insurance plan.

☐ I am a full-time Master's degree student. I understand that I must pay the University Health Services fee regardless of enrollment or waiver of the Student Health Program medical insurance. I am requesting to opt out of the Student Health Program (SHP) insurance plan.

☐ I am a trainee in School of Medicine and am requesting a medical insurance waiver because I have acceptable alternative insurance as described on this form.

☐ I am a visiting medical student in the School of Medicine and am requesting a medical insurance waiver because I have acceptable alternative insurance as described on this form.

☐ OTHER: I am a _____ in the School of Medicine and am requesting a medical insurance waiver because I have acceptable alternative insurance as described on this form. (OTHER is defined as a part-time postdoctoral fellow or summer anatomy student).

MINIMUM REQUIREMENTS FOR ALTERNATIVE INSURANCE:

• Emergency Services: care received for conditions that could lead to serious disability or death if not immediately treated, not penalized for going out-of-network or not having prior authorization.
• Hospitalization: treatment in a hospital for inpatient care including laboratory services and medication during the hospital stay.
• Laboratory services: testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment.
• Maternity, newborn care and breastfeeding coverage: Care that women receive during pregnancy, through delivery, post-delivery and care for newborns.
• Mental health services and addiction treatment: inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. Limits must comply with state or federal parity laws.
• Outpatient Care: care received without being admitted to a hospital such as a doctor's office or clinic.
• Pediatric services: well-child visits, vaccines, immunizations, dental and vision care
• Prescription drugs, including birth control coverage: medications that are prescribed by a doctor to treat an illness or condition, some prescription drugs can be excluded.
• Preventive services, wellness services and chronic disease management: including physicals, immunizations and screenings designed to prevent or detect certain medical conditions.
• Rehabilitative services and devices: Services to help recover or develop skills and device to help gain or recover mental and physical skills due to injury, disability or chronic condition.
• Plan allows the insured to visit U.S. doctors, hospitals, laboratories and other health care providers in the Baltimore/Washington, DC metropolitan area or local area where the insured will be residing and studying for the academic year and is not limited to emergency-only care.
• Plan is not an out of state Medicaid plan.

ALTERNATIVE MEDICAL INSURANCE INFORMATION

This section must be completed and a copy of the current medical insurance card must be submitted with this form.

Insurance Company Name: _____

Name of primary subscriber: _____

Policy/Member Number: _____ **Effective date**: _____

FINANCIAL RESPONSIBILITY STATEMENT

- I have read and understand the required coverage information for alternative insurance on the reverse side of this form.
- I understand that I may only enroll myself and/or my eligible family members in the Johns Hopkins University School of Medicine Student Health Program (SHP) insurance plan during the announced open enrollment period or, outside of open enrollment, only should a qualified life event occur that would permit enrollment. I understand that documentation is required for all Qualified Life Events. Qualified life events can include:
    - Involuntary loss of other coverage through parent or spouse
    - Marriage
    - Birth or adoption of a child
    - Start or loss of your spouse/domestic partner's employment
    - Divorce or termination of domestic partnership
    - Death of your spouse/domestic partner or child
    - Spouse/partner/child moving to the United States to reside with the learner for more than three months
- I understand that, by waiving the Student Health Program sponsored by The Johns Hopkins University, I am accepting full financial responsibility for hospital, laboratory, physician, diagnostic testing and other medical costs not covered by my insurance.
- I acknowledge the risk of inadequate health insurance coverage could affect my finances and my credit standing.

_____ _____
Signature of Student or Trainee Date