2013-2014 Petition to WAIVE
United States Merchant Marine Academy Student Health Insurance Plan
Waiver Deadline 06/03/2013

Plebe Candidates Name: _____ Date of Birth:____/___/_____

Email Address:_____

Please fill in all of the above information so we can contact you with any questions.

Waiver: I certify that I am insured under the following medical insurance plan and that it meets the following criteria.

**If your coverage does not meet each of these conditions, you may not waive. You will remain enrolled in the USMMA Student Health Insurance Plan (SHIP). If you do not know whether your coverage meets these conditions, contact your health insurance plan administrator to obtain current, accurate information about your plan before completing this form. If your health plan does not meet these criteria, your health plan does NOT qualify as "comparable coverage"

Please note: You cannot waive the Merchant Marine coverage if you have Kaiser Permanente or a HMO Plan.

NOTE: Incomplete waiver forms cannot be accepted.

All Plebe are required to be enrolled in an Insurance Plan.

Does Your Insurance Policy Provide the following:
1.) Will your current coverage remain in effect through June 30, 2014? (Coverage renewing on January 1, will meet this requirement) ❑ Yes ❑ No
2.) Is your insurance company headquartered/operated in the United States with a US Claims address and Customer Service phone number? ❑ Yes ❑ No
3.) Does your current plan provide both emergency and non-emergency benefits for medical and mental health treatment? ❑ Yes ❑ No
4.) Does your current plan provide inpatient hospitalization, outpatient physician visits, laboratory services, radiology and outpatient mental health benefits? **Coverage limited to Emergency care does not satisfy this requirement.** ❑ Yes ❑ No
5.) Does your plan allow for utilization of hospital and providers within 25 miles of the Academy for non-emergency care? ❑ Yes ❑ No
6.) Does your plan provide coverage in all 50 states and internationally? ❑ Yes ❑ No
7.) Does your coverage comply with all Federal and/or New York State regulations for student health insurance? ❑ Yes ❑ No

Your Insurance information:

Subscriber's Name:_____ Group Policy Number: _____

Relationship of Policyholder to Student: ❑Parent/Guardian ❑Spouse/Domestic Partner ❑Self

Policy or Subscriber #:_____Eff Date___/__/_____Insurance Company: _____

Insurance Company Telephone Number-this must be a U.S. phone number (used to verify coverage)___/___/_____

I understand that I am requesting to waive the USMMA insurance coverage; I have comparable coverage through another insurance company. I further understand that I am responsible for all my medical expenses. I understand this petition is subject to approval and the decision is FINAL.

Date: _____/_____/_____ Signature: _____

Complete this form and return mail, email or fax below.

The Allen. J. Flood Companies
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Fax: 914.922.9291