Emory University requires that all degree-seeking and international students either have health insurance or purchase the University-sponsored plan. In order to waive enrollment in the University-sponsored plan, newly enrolled and continuing students for Spring 2018 must show evidence of enrollment in a United States domiciled health insurance plan that meets waiver criteria. However, some Emory students may have failed the waiver process (or failed to complete the process by the deadline date) and yet may feel that they should be exempted from this requirement. Therefore, the University has created a Student Health Insurance Requirement Appeals Committee, consisting of students, faculty and staff, to review and vote upon requests for reconsideration of denied waivers. Please note that this appeals process is only for newly enrolled students for Spring 2018.

The committee will make every effort to decide upon appeals prior to the start of insurance coverage for the Spring Semester. However, should a student be charged for the Emory plan and the committee subsequently decides to grant the waiver after consideration of the appeal, the charge will be reversed by Student Financial Services. The appeals deadline for Spring 2018 is February 8, 2018 since this is the date that Emory will have to pay the insurance company the premium for your enrollment in the plan.

Student Name: ___________________________________________ Date of Request: ____/____/_______

Emory Student ID#: ____________________ Emory College or School: _______________________

Academic Level: Freshmen ☐ Sophomore ☐ Junior ☐ Senior ☐ Transfer Student? Yes ☐ No ☐

Student’s Phone Number: (_____)_________________ E-mail address: __________________________

Please state below the reason(s) you believe that you should be exempted from the Emory student health insurance requirement despite failing (or failing to complete) the waiver process (attach additional sheets if necessary). If you are appealing because your current insurance coverage does not meet the waiver requirements, but you feel that it provides you with appropriate coverage, please attach a copy of your schedule of benefits (it is usually found in chart form in your insurance plan’s brochure):

In order to assist the committee in reviewing your appeal, please also complete the additional information on the attached page. Please return this completed 2 page form and any additional attachments/supporting documents to:

By standard mail to: Emory University Student Health Services, Insurance Office, Attn: Appeals Committee, 1525 Clifton Road, Atlanta, GA 30322, by email to: ktaylor2@emory.edu, or by fax to: 404-778-6668 or 404-727-7265.

If you have questions, please contact: Kimberly Taylor, Assoc. Dir, @ ktaylor2@emory.edu or 404-727-7560
Additional information that will be used by the Appeals Committee to review your request:

Student name: ___________________________________________ Emory Student ID#______________

Name of your insurance company______________________________________________________________

Individual annual deductible for the student: $ _______ Family annual deductible (if applicable): $ ________

Number of family members insured under the plan (including the student): _______

Policy Holder’s Name: ________________________________________________________________

Policy Holder’s ID #_________________ Policy or Group # of Policy Holder: ________________________

Insurance Address or PO Box: ________________________________________________________________

City/State/Zip Code: ______________________________ Telephone #: (_____) _____--__________

Are you eligible to enroll as a dependent on your parent’s plan until the age of 26 under the Affordable Care Act?   Yes □   No □

Are you enrolling in a plan that is a part of the Affordable Care Act? Yes □   No □

Have you submitted an appeal in the past? Yes □   No □ If yes, what was the outcome? Approved □   Denied □

Does your insurance plan provide inpatient and outpatient coverage in Atlanta, Georgia? Yes □   No □

Does your insurance have an individual annual deductible not greater than $2,500 per policy year? If no, do you/family have an approved Healthcare Savings Account (HSA) to supplement the deductible expenses? Yes □   No □

Is your insurance underwritten by a company domiciled in the United States? Yes □   No □

If no, does your foreign insurance company have a United States partner that administers claims and payments? Yes □   No □ If yes, what is the name of the United States claims administrator and where is it located?

Name: ______________________________________________________

Office Location (US City and State): ________________________________________________