2012–13 Student Health Insurance Requirement

APPEAL INFORMATION FOR GRADUATE AND PROFESSIONAL STUDENTS

INTRODUCTION

Cornell’s policy establishes the Student Health Insurance Plan (SHIP) as mandatory for all graduate and professional students. It also creates an option for students to file a written appeal if you believe you have other comparable health insurance. If the appeal demonstrates that your health insurance meets all six of Cornell’s criteria, you will not be required to enroll in the SHIP and pay the SHIP premium.

PRIMARY CARE AT GANNETT HEALTH SERVICES

Whether you have the Student Health Insurance Plan or other health insurance, Gannett Health Services provides primary medical care and counseling when you are in the Ithaca area.

All full-time registered students can meet with a Gannett health care provider or counselor for a $10 student visit charge. Most other services at (e.g., lab, xray, some preventive services) are covered for those enrolled in the SHIP. For students who have private health insurance, fees are charged for most services. Carefully review your health insurance policy to make sure it will provide adequate coverage for your health care needs. Gannett does not bill private insurance companies directly, but will provide a receipt for services you can submit to your insurance company for reimbursement.

Confidentiality: All medical care and counseling at Gannett is confidential. Gannett staff members confer with one another as needed to provide integrated care for you; in the event of your treatment at Cayuga Medical Center or another hospital, the hospital and Gannett will share relevant health information for continuity of care. Otherwise, Gannett will not release any information about you without your written permission, except as authorized or required by law, or in our judgment as necessary to protect you or others from a serious threat to health or safety.

For more information about Gannett, visit www.gannett.cornell.edu.

APPEAL APPLICATION

You must fill out the Appeal Application if you wish to appeal and are a: 1) new student; 2) continuing student appealing for the first time; or 3) continuing student whose private health insurance has changed from the policy that was approved last year. In the application, you must affirm that you include the required supporting documents, properly marked to demonstrate coverage that meets all six of Cornell’s criteria; you submit your fully completed application by the deadline; and you have not used the SHIP.

DEADLINE FOR SUBMITTING APPEAL APPLICATIONS

Your Appeal Application and supporting materials are due to the Office of Student Health Insurance by:

Fall Entrants: Sept. 30. Appeals received after this date will incur a late fee of $50 for each month late. No appeals will be accepted after Dec. 10.

Spring Entrants: Feb. 28. Appeals received after this date will incur a late fee of $50 for each month late. No appeals will be accepted after Apr. 15.

APPROVAL OF AN APPEAL APPLICATION

Your Appeal Application will be approved if:

1. you submit your fully completed application by the deadline; and
2. you include the required supporting documents, properly marked to demonstrate coverage that meets all six of Cornell’s criteria;
3. you submit a current copy of your insurance membership card and
4. you have not used the SHIP.

The Office of Student Health Insurance will communicate with you via your CU netid and notify the Office of the Bursar, indicating that your Appeal Application has been approved. Your SHIP coverage will be cancelled. The Office of Student Health Insurance will issue a credit to your Bursar account for the premium. The Office of the Bursar will waive finance charges if filed by deadline.

DENIAL OF AN APPEAL

Your appeal will be denied if you do not provide proof, by the deadline, that you carry health insurance that meets all six of Cornell’s criteria. Incomplete applications cannot be processed and will be returned to you for completion. The Office of Student Health Insurance will communicate with you via your CU netid and will alert the Office of the Bursar, indicating that your Appeal Application has been denied. You will be responsible for the SHIP premium (charged to your Bursar account and payable immediately) and remain enrolled in the SHIP.

If you prefer to spread out your payments, you may request the installment plan payment option from the Office of Student Health Insurance.

CORNELL OFFICE OF STUDENT HEALTH INSURANCE

Address: 409 College Avenue, Suite 211 Ithaca, NY 14850
Phone: 607 255-6363 E-mail: sicu@cornell.edu
Fax: 607 254-5221 Web: www.studentinsurance.cornell.edu

PROOF OF COVERAGE

As part of your Appeal Application, you must submit proof that you have health insurance coverage that meets all six of Cornell’s criteria. (See application form for details.) This information must be in English.
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APPEAL APPLICATION FOR GRADUATE AND PROFESSIONAL STUDENTS

Name ___________________________ Date of Birth (mm/dd/yyyy) ___________________________ Gender ___________________________

7-Digit Cornell ID # ___________________________ School/Program ___________________________

HEALTH INSURANCE INFORMATION

Insurance Company ___________________________ CU Netid ___________________________

Subscriber Name ___________________________ Subscriber ID # ___________________________

Subscriber Date of Birth (mm/dd/yyyy) ___________________________ Insurance Policy # ___________________________

Subscriber’s Relationship to Student ___________________________ Insurance Co. Address ___________________________

Insurance Co. Phone # ___________________________

STEP ONE: INFORMATION ABOUT YOUR HEALTH INSURANCE PLAN

If you have health insurance that satisfies Cornell’s six criteria and do not wish to purchase the Student Health Insurance Plan (SHIP), please indicate by checking all six of the “yes” boxes below. If your coverage does not meet all six of these criteria, your appeal cannot be renewed and you must purchase the SHIP.

YES NO

☐ ☐ 1. My plan is provided by a company licensed to do business in the United States, with a US claim payment office and US phone number.

☐ ☐ 2. My plan provides coverage in the Ithaca area for outpatient and inpatient medical care. (A policy that provides coverage in the Ithaca area on an “emergency care only” basis does not meet this requirement.)

☐ ☐ 3. My plan provides coverage in the Ithaca area for outpatient and inpatient mental health care.

☐ ☐ 4. The maximum benefit for my coverage is at least $500,000 per year.

☐ ☐ 5. My coverage will remain in force as long as I am a full-time registered student (including in absentia and non-degree status) at Cornell University.

☐ ☐ 6. My plan provides coverage for pre-existing conditions.

STEP TWO: PROOF OF COVERAGE

Both of these documents must be included for an appeal application to be accepted. Benefit information must be in English.

☐ I have attached a copy of my insurance identification card that includes my name (or the “Subscriber Name,” written above, and family, spouse, or domestic partner coverage indicated).

☐ I have attached a document (e.g., a benefit booklet, policy statement) and highlighted the sections that demonstrate that my plan meets each of Cornell’s six criteria detailed above. I have numbered the highlighted sections to correspond to the requirements listed above (#1 through #6).

NOTE: Cornell University reserves the right to verify insurance information. If your plan does not meet these criteria, or you are uninsured, your appeal will be denied, and you will automatically be charged for and enrolled in the Student Health Insurance Plan.

STEP THREE: SIGNATURE

By my signature, I affirm that I have read and understand the information in the Appeal Instructions and Application. I hereby request an appeal of the requirement of enrollment in the SHIP, based on the included supporting documentation showing that I have health insurance coverage that meets all six of the criteria described above. I understand I am legally responsible for all medical expenses incurred during my enrollment at Cornell University and that the University will not be responsible for any medical expenses.

Signature ___________________________ Date (mm/dd/yyyy) ___________________________

RETURN TO: Cornell Office of Student Health Insurance

409 College Avenue, Suite 211
Ithaca, NY 14850