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 another plan that meets Cornell's criteria for adequate coverage. These criteria, established each year by the Student Insurance Advisory Committee, are based on the actual experiences of Cornell students who sought health care using a variety of insurance plans. If your application demonstrates that your health insurance meets all seven of Cornell's criteria, you will not be required to enroll in the SHIP.

WHO SHOULD COMPLETE AN APPEAL APPLICATION?

Submit the application if you wish to appeal and are a:

- new student
- continuing student appealing for the first time
- continuing student whose appeal was approved last year

The criteria have changed for 2013-14. If you have concerns about the implications of these changes on commitments you have made based on last year’s appeal approval, please consult with the Office of Student Health Insurance.

CRITERIA FOR APPROVAL OF ALTERNATE HEALTH INSURANCE

Your plan must:
1. be provided by a company licensed to do business in the United States, with a U.S. claims payment office and a U.S. phone number.
2. have a maximum benefit of at least $500,000 per year.
3. have a policy year deductible of $2,500 or less.
4. be in force for the duration of the academic year, or until your program ends.
5. provide coverage for medical and mental health care where you are attending school (Ithaca or elsewhere) at a reimbursement rate of at least 70% of US based Reasonable and Customary. Coverage must include inpatient and outpatient emergency, urgent, and routine care.
7. not require you to leave the U.S., return to country of origin, or home country for medical or mental health care.

PROOF OF COVERAGE

As part of your Appeal Application, you must submit proof that you have health insurance coverage that meets all seven of Cornell's criteria. (See application form for details.) This information must be in English.

DEADLINE FOR SUBMITTING APPEAL APPLICATIONS

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.

APPEAL INFORMATION FOR GRADUATE AND PROFESSIONAL STUDENTS

APPROVAL OF AN APPEAL

Your appeal 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 seven of Cornell's criteria; and
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 Cornell netid and notify the Office of the Bursar, indicating that your appeal 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 have insurance that meets all seven 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 (OSHI)

Send your Appeal Application and supporting documents to OSHI.

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

HEALTH CARE AT GANNETT HEALTH SERVICES

Whether you have SHIP or other health insurance, Gannett Health Services (www.gannett.cornell.edu) provides confidential 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 charge. Most other services (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 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 company for reimbursement.
2013–14 Student Health Insurance Requirement

APPEAL APPLICATION FOR GRADUATE AND PROFESSIONAL STUDENTS

Name ___________________________ Date of Birth (mm/dd/yyyy) ___________ Gender ___________ 7-Digit Cornell ID # ___________ CU Netid ___________________________ School/Program ___________________________

HEALTH INSURANCE INFORMATION

Insurance Company ___________________________ Subscriber ID # ___________________________

Subscriber Name ___________________________ Subscriber Date of Birth (mm/dd/yyyy) ___________

Subscriber’s Relationship to Student ___________ Insurance Policy # ___________________________

Insurance Co. Address ___________________________ Insurance Co. Phone # ___________________________

STEP ONE: INFORMATION ABOUT YOUR HEALTH INSURANCE PLAN

If you have health insurance that satisfies Cornell's seven criteria and do not wish to purchase the Student Health Insurance Plan (SHIP), please indicate by checking all seven of the "yes" boxes below. If your coverage does not meet all of these criteria, your appeal will not be approved 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 has a maximum benefit of at least $500,000 per year.

☐ ☐ 3. My plan has a policy year deductible of $2,500 or less.

☐ ☐ 4. My coverage will remain in force for the duration of the academic year, or until my program ends.

☐ ☐ 5. My plan provides coverage for medical and mental health care where I am attending school (Ithaca or elsewhere) at a reimbursement rate of at least 70% of US based Reasonable and Customary. My coverage includes inpatient and outpatient emergency, urgent, and routine care.


☐ ☐ 7. My plan does not require me to leave the U.S., return to my country of origin, or my home country for medical or mental health care.

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 seven criteria detailed above. I have numbered the highlighted sections to correspond to the requirements listed above (#1 through #7).

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 seven 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