

**REMINDER:**  
due date to return  
is Monday,  
August 14, 2017

**The Juilliard School  
2017-2018  
Student Health Insurance Waiver Form**

**COMPLETE THIS FORM ONLY IF YOU DECIDE TO WAIVE THE HEALTH INSURANCE COVERAGE**

Student Name: \_\_\_\_\_  
Last First  
Home Address: \_\_\_\_\_  
Street  
\_\_\_\_\_  
City, State, Zip Phone #  
Student's ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
mm / dd / yyyy

The Juilliard School recommends that all students have health insurance that covers, at a minimum, the following:

- Coverage for New York City medical providers and hospitals
- Coverage for both outpatient and in-patient care, laboratory and diagnostic services - not just catastrophic or emergency coverage
- Direct payment to providers, versus a reimbursement plan that requires payment first
- The maximum benefit payable under the insurance plan must be unlimited
- Policy in effect for the entire academic year, September 2017 through May 2018

**We advise you to speak with your insurance company to determine if your policy provides adequate coverage as detailed above.** For example, if you are insured under an HMO or other policy that does not pay for routine medical care in case of Sickness or Injury, emergency room treatment, and hospitalization in New York City you should not waive the student health insurance. You may call the Juilliard School Health Service office at (212)799-5000 ext. 282 if you have any questions.

When the student health insurance is waived, all students who are enrolled in 6 credits or more per semester are entitled to medical and mental health services provided by the Juilliard Health and Counseling Services. Costs for the services provided by the Juilliard Health and Counseling Services are covered by the general operating budget of the school. Please note that there will be charges for medications, immunizations, laboratory work, and miscellaneous medical equipment as a result of these services.

**International students may NOT waive coverage of the Student Health Insurance Program.**

**Directions to complete the Insurance Waiver Form:**

- Complete both sides of this form.
- The policyholder and the student both must sign the form.
- A photocopy of the front and back of the student's health insurance card must be attached.
- The completed waiver form with a photocopy of the insurance card must be received by the Student Accounts Office at The Juilliard School by August 14, 2017. If complete, the Student Accounts Office will remove the \$967 per semester fee from the student's tuition account.
- A waiver form must be completed for each academic year that a student does not want to be enrolled in the Juilliard Student Health Insurance Program.

***Incomplete forms or forms received without a photocopy of the insurance card will not be accepted.***

**Return this form by mail to the STUDENT ACCOUNTS OFFICE,  
60 Lincoln Center Plaza, New York, NY 10023 or by fax to (646)505-4102**

**\*\*\*CONTINUED ON REVERSE\*\*\***

**INSURANCE COMPANY INFORMATION:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street

\_\_\_\_\_  
City, State, Zip

Telephone Number: \_\_\_\_\_

*Please provide the customer service or medical emergency number, if available.*

*If not, please list the telephone number of the insurance company.*

**POLICYHOLDER INFORMATION:** *(The person under whom the student's health coverage is effective)*

Name: \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address: \_\_\_\_\_

Street (if same as home address of the student list "same")

\_\_\_\_\_  
Phone # \_\_\_\_\_

\_\_\_\_\_  
City, State, Zip

Name of Policyholder's Employer: \_\_\_\_\_

**POLICYHOLDER AFFIRMATION:**

I declare that the student on the front side of this form is enrolled for the health insurance coverage listed on this form and that this health insurance will provide medical coverage and benefits (as detailed on the reverse side) for medical charges that may be incurred in New York City. Additionally, if the student becomes ineligible for this coverage during this school year (ending May, 2018) for any reason, or if this health insurance policy proves to be inadequate for any reason, I understand that uninsured medical charges could result in substantial financial liabilities. I have not relied on any representative of The Juilliard School in determining the adequacy of the named student's health insurance program. I understand the ability to re-enroll in the Student Health Insurance Program is not guaranteed and can only be explored if the student completes a late enrollment form (available in the Student Accounts Office) within 60 days of the date of loss/termination of the student's health insurance coverage as described on this form.

Signature of policyholder: \_\_\_\_\_ Date: \_\_\_\_\_

**STUDENT AFFIRMATION:**

I have read and understand the above affirmation, I agree with its representations, and I have not relied on any representative of The Juilliard School in determining the adequacy of my health insurance coverage. I understand the potential serious financial ramifications of waiving the Student Health Insurance coverage.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

\*Signature of Parent/Guardian

if student is under 18 years of age: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

***Remember: No form will be considered complete without a copy of the front and back of the student's health insurance card.***

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