Barry University

School of Podiatric Medicine & Physician Assistant Program Insurance Waiver
2014-2015 Academic Year

All students in the Barry School of Podiatric Medicine and Physician Assistant Program are **required** to provide proof of adequate health insurance (copy of insurance card front and back) along with the completed insurance waiver below by uploading to the American DataBank (ADB) Immunization Tracking System at www.barrypa.com . Proof must be uploaded prior to matriculation. Students may not lapse in coverage. Any changes to your insurance plan will require a new waiver form to be completed and uploaded along with insurance card to your ADB profile.

Failure to comply with the Policy will negatively affect the Student's registration and/or the Student's participation in clinical rotations.

It is strongly recommended that students call to verify that the policy covers the requirements listed below prior to submitting this waiver.

Existing Coverage Information

Please answer the following questions to determine if your current coverage exempts you from purchasing the school's recommended insurance coverage.

1. ☐ YES ☐ NO Does your policy allow access to primary care; (Physician Office Visits, Urgent, and Emergent Care) **Emergency only care is not comparable coverage.**

2. ☐ YES ☐ NO Does your policy provide inpatient coverage of 80% of usual and customary reimbursement?

3. ☐ YES ☐ NO Does your policy provide prescriptive medications at a local pharmacy?

4. ☐ YES ☐ NO Does your policy provide inpatient and outpatient mental health benefits (including alcohol and substance abuse treatment)?

5. ☐ YES ☐ NO Does your policy have an individual deductible less than $2500 per policy year?

6. ☐ YES ☐ NO If you are enrolled in the Miami or St Petersburg campus, is the insurance company licensed to do business in the State of Florida?

   If you are enrolled in the St Croix campus, is the insurance company licensed to do business in the USVI?

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7. ☐ YES ☐ NO Does your policy have maternity benefits (women only)?

Birth Date of Policy Holder

Student First Name

Student Last Name

Email

Student ID Number

Campus Location

Private Insurance Company Name

Policy #

Group #

Insurance Company Phone #

Name of Policy Holder

By signing this form I am affirming that for the current academic year my private health insurance policy is adequate coverage as defined above (and if international also covers the items listed above). I hereby release Barry University, Inc., and its trustees, officers, employees, students, agents, and independent contractors of any responsibility for my health care and I agree to assume all financial responsibility for any medical expenses that I incur while attending Barry. I understand that even though I have private health insurance, I am eligible for the Barry University Student Health Plan and may enroll on a voluntary basis. For information on enrollment student may contact the Student Health Services at www.barry.edu/healthservices.com and/or 305-899-3750.

By signing this I understand that Barry University reserves the right to request written confirmation of my private health insurance policy from my insurance carrier if my health coverage is in question. Failure to comply with this request may disrupt my registration and/or my clinical participation in the Program.

Student Signature

Date