AMERICAN UNIVERSITY of ANTIGUA | COLLEGE OF MEDICINE

american international college of arts and sciences | antigua

# PROOF OF INSURANCE EVALUATION FORM 2020-2021

AUA provides health care insurance from United Health Care for all students. Students can OPT OUT of the University provided plan by submitting this form to **insurance@auamed.org**. Forms must be received no later than ==JULY== 20 prior to the August – January coverage period and no later than ==January== 20 for prior to the February – July coverage period. Please indicate "OPTING OUT OF INSURANCE" on the subject line of the email when submitting this form.

| **Student last name** (Please Print) | **Student first name** (Please Print) | **Student ID** |
|---|---|---|
| | | |

**Your Health Insurance Carrier**_____

**Policy Number/Group Number**_____

**Carrier phone number**_____

**MINIMUM COVERAGE LIMITS THAT YOUR PLAN SHOULD HAVE (see 2nd bullet point in Student Attestation section below):**
- **Coverage up to $100,000 per accident or illness OR $200,000 minimum aggregate**
- **Maximum deductible of $1,000 per covered person**
- **Must cover office visits – EMERGENCY and NON-EMERGENCY (No emergency-only plans)**
- **Must include international coverage**

## Student attestation:

**By signing below I:**
- **Attest to the accuracy of the information above.**
- **Agree that AUA is not financially responsible for any out-of-pocket expense incurred by the student from any injury or sickness claim if my coverage does not meet any or all of the minimum coverage points above.**
- **Acknowledge misconduct actions may be taken against me if above information is found to be fraudulent or a misrepresentation, and agree that upon such findings AUA shall not be responsible, legally or financially, for any health issues incurred by me, including death.**
- **Authorize AUA to conduct investigation into the validity of information above.**
- **Agree to maintain above coverage and will notify AUA if my carrier changes.**
- **Agree to submit a new Proof of Insurance form as may be reasonably requested from time to time by AUA.**
- **Acknowledge responsibility for any unsettled claims arising from use of the on campus clinic.**

| **Student signature** | | **Date** | |
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