Barry University
SCHOOL OF PODIATRIC MEDICINE

Barry School of Podiatric Medicine Insurance Waiver
Fall 2014- Summer 2015 Academic Year

All students attending the Barry University School of Podiatric Medicine are **required** to provide proof of adequate health insurance in order to maintain their status in the podiatric program. Proof of insurance, including copy of front & back of card and this completed insurance waiver, must be uploaded to the American DataBank (ADB) Immunization Tracking System at www.barrygx.com prior to registration or you may be unable to register for the upcoming semester. 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 copy of insurance card to your ADB profile. NO INSURANCE COVERAGE IS ASSESSED AUTOMATICALLY. YOU MUST ENROLL IF YOU CHOOSE TO PARTICIPATE IN BARRY STUDENT HEALTH INSURANCE.

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 you verify with your insurance company that your policy covers you for 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
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 — Is the insurance company licensed to do business in the State of Florida
7. ○ Yes ○ No — Does your policy provide maternity benefits (women only)

Birth Date of Policy Holder	ex: mm/dd/yyyy
Student First Name	
Student Last Name	
Email	
Student ID Number	
Campus Location	
Private Insurance Company Name	
Policy #	
Group #	
Insurance Company Phone #	ex: XXXXXXXXXX
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 will assume all financial responsibility for any medical expenses that I incur while attending Barry University. 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	ex: mm/dd/yyyy

Submission of this waiver does not automatically guarantee waiver acceptance. Students are notified via email if the waiver is not accepted.