



**Center for Student Health & Counseling**  
 1880 SW 6<sup>th</sup> Avenue, Suite 200  
 Portland, OR 97201  
 503.725.2800 (O) 503.725.5812 (F)  
 www.pdx.edu/shac



## PSU Student Health Insurance Plan Appeal for Missed Insurance Waiver Deadline

The deadline to waive the Student Health Insurance Plan is midnight on Sunday of the second week of each term.

- A PSU student will be granted only **one** (1) Missed Insurance Waiver Deadline exception for the duration of their enrollment at PSU as long as the student’s private health insurance plan meets the University’s waiver criteria and is showing actively insured from the beginning of the term in question.
- This form must be returned to the Insurance Team in the Center for Student Health & Counseling (SHAC) by the close of business on the Friday before each term’s finals week (see “Term Dates” in PSU Academic Calendar). Appeal forms submitted after this day will **not** be considered.
- You will be notified of our determination within fourteen (14) business days from the date the appeal form was received in SHAC.
- Please note: If you have used any of the plan benefits from the start of this term’s policy coverage through today, you will remain enrolled in the plan for this term and the plan premium will remain on your student account. You will have opportunity to complete an online waiver application for the following term.

Submit the completed appeal form with the required supportive documentation to SHAC in one of the following ways:

- Deliver it to SHAC in the University Center Building (UCB) Suite 200, 1880 SW 6<sup>th</sup> Avenue
- Email a scanned completed form and supporting documentation to [insurancehelp@pdx.edu](mailto:insurancehelp@pdx.edu)
- Fax it to Attention: SHAC Insurance Team, 503.725.5812

INFORMATION ABOUT YOU	
<b>Name:</b>	<b>Today’s date:</b>
<b>Student ID#:</b>	<b>Phone number:</b>
<b>For which term in this academic year are you appealing?</b> (check one) <input type="checkbox"/> Fall <input type="checkbox"/> Winter <input type="checkbox"/> Spring/Summer <input type="checkbox"/> Summer Only	<b>PSU email address:</b>
INFORMATION ABOUT YOUR PRIVATE HEALTH INSURANCE PLAN	
<b>I receive my health insurance coverage through a/an</b> (check one): <input type="checkbox"/> Employer <input type="checkbox"/> Parental/Family Plan <input type="checkbox"/> OHP <input type="checkbox"/> Other _____	<b>How many people are covered by your health insurance plan?</b> (check one only) <input type="checkbox"/> Just me. <input type="checkbox"/> Me and my family. Please indicate total number of family members covered: _____
<b>I have the following in addition to my private health insurance plan</b> (check all that apply): <input type="checkbox"/> Health Savings Account (HSA) <input type="checkbox"/> Flex Spending Account (FSA) <input type="checkbox"/> secondary health insurance plan	

## Supporting Documentation

This appeal form must be accompanied by proof of a comparable private health insurance plan.

Proof must include:

- A copy of both the front and back of your health insurance card.
- A Plan Benefit Summary of your health insurance coverage. The Plan Benefit Summary must also state the plan deductible and the percentage of hospitalization covered by your insurer. This information is most often found on your insurance carrier website.

Criteria for a Comparable Private Health Insurance Plan:

- Your private health insurance plan must have an individual deductible of \$2500 or less.
  - Be sure you let us know the number of family members on your plan, if applicable.
  - Consideration will be given to Health Savings Accounts (HSA) or Flex Plans if the deductible for your private insurance plan is higher than \$2,500.
    - The most recent statement of your HSA or Flex Plan must be submitted with this appeal form or your HSA or Flex Plan will not be taken into consideration.
- Your private health insurance plan must provide hospitalization coverage of 70% or greater.
- Your private health insurance plan must offer you primary care in Oregon (not just Emergency)

(Optional) Include a signed [FERPA Release Form for Student Health Insurance](#) so my information regarding the PSU Student Health Insurance Plan and the waiver process can be shared with my designee.

## Agree to Terms and Conditions

**Initial next to each item to indicate your understanding of and compliance with the terms and conditions of the missed insurance waiver deadline appeal process:**

\_\_\_\_\_ I understand that I am granted **ONE** Missed Waiver Deadline Appeal (whether approved or denied) for the duration of my enrollment at PSU.

\_\_\_\_\_ I understand that if I used any plan benefits during the term for which I am appealing, my appeal will be denied and the charge for the insurance premium will remain on my student account.

\_\_\_\_\_ I understand that if my health insurance policy coverage does not meet the waiver criteria I will not be permitted an approval of this appeal.

\_\_\_\_\_ Whether my appeal is approved or denied, I understand that it is my responsibility to apply for a waiver during the next waiver period.

\_\_\_\_\_ I understand that all communication regarding student health insurance, the waiver process and deadlines, or any other health-related information is **sent to my PSU email account**. It is my responsibility to read my PSU emails so I do not miss important information such as an impending waiver deadline. I also understand that I have the option to forward my PSU email account to my private account at any time.

**My signature represents my understanding of the above stated Terms and Conditions, and that all the information provided on this appeal form is accurate to the best of my knowledge.**

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Student Signature

Today's Date