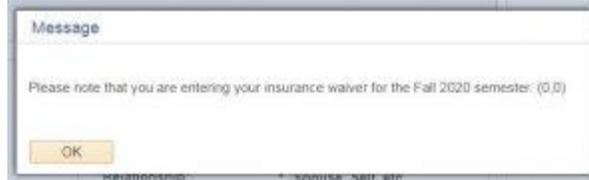


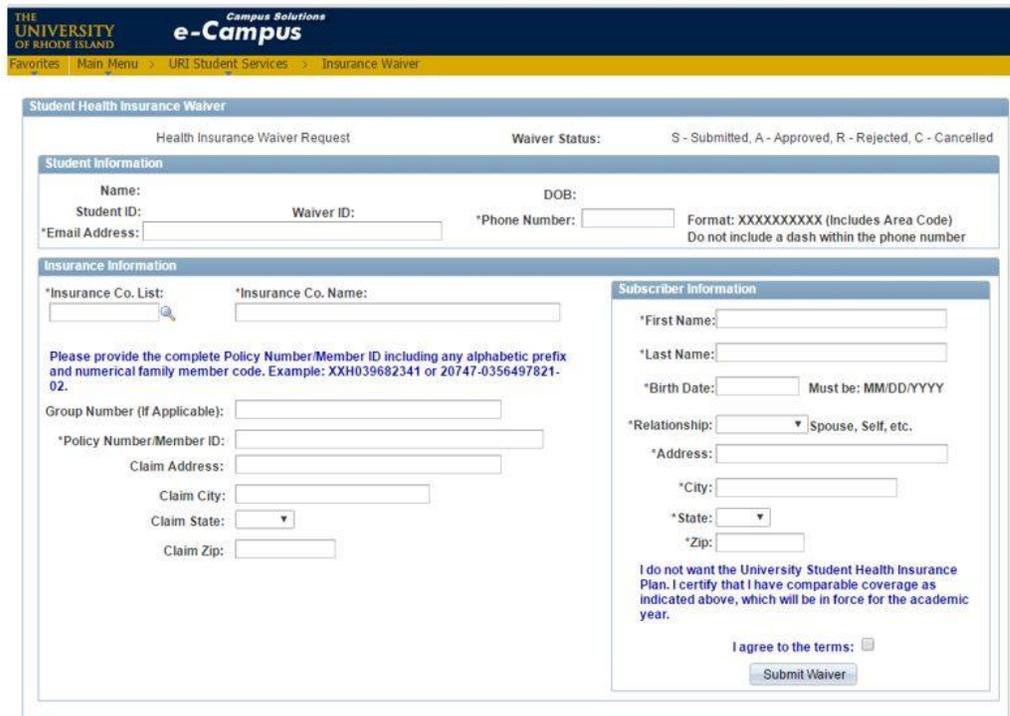
How do I submit my insurance waiver?

- Log into [e-Campus](#)
- Select “URI Student Services” from the menu
- Now, select “Insurance Waiver”. You will see the following message indicating the term you are



submitting a waiver for:

- Now, click “OK”. You will see the following screen

A screenshot of the "Student Health Insurance Waiver" form on the e-Campus website. The form is titled "Student Health Insurance Waiver" and includes a "Waiver Status" section with options: S - Submitted, A - Approved, R - Rejected, C - Cancelled. The form is divided into several sections: "Student Information" (Name, Student ID, Waiver ID, Email Address, Phone Number, DOB), "Insurance Information" (Insurance Co. List, Insurance Co. Name, Policy Number/Member ID, Group Number, Claim Address, Claim City, Claim State, Claim Zip), and "Subscriber Information" (First Name, Last Name, Birth Date, Relationship, Address, City, State, Zip). There is a checkbox for "I do not want the University Student Health Insurance Plan. I certify that I have comparable coverage as indicated above, which will be in force for the academic year." and a "Submit Waiver" button at the bottom right.

- Enter your preferred email address, which we will use to contact you regarding the status of your insurance waiver.
- Enter your 10 digit preferred phone number. Please **do not** insert any dashes (-).
- Click on the magnifying glass to the right of the “Insurance Company list” field.

Health Insurance Waiver Request Waiver Status: S - Submitted, A - Approved, R - Rejected, C - Cancelled

Student Information

Name: _____ DOB: _____
 Student ID: _____ Waiver ID: _____ *Phone Number: _____ Format: XXXXXXXXXX (Includes Area Code)
 *Email Address: _____ Do not include a dash within the phone number

Insurance Information

*Insurance Co. List: *Insurance Co. Name:

Please provide the complete Policy Number/Member ID including any alphabetic prefix and numerical family member code. Example: XXH039682341 or 20747-0356497821-02.

Group Number (If Applicable):
 *Policy Number/Member ID:
 Claim Address:
 Claim City:
 Claim State:
 Claim Zip:

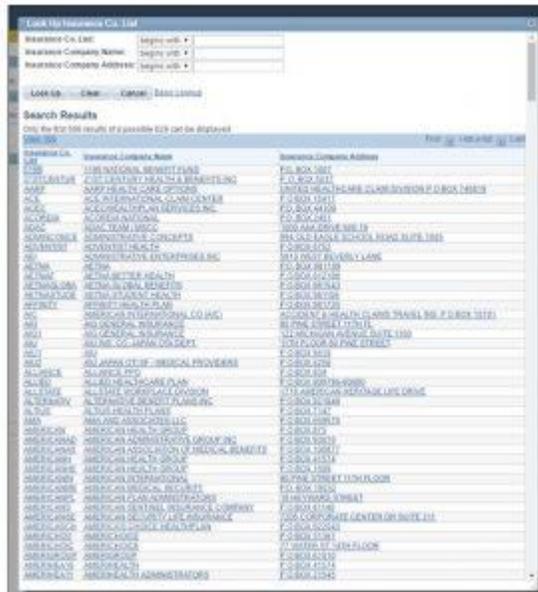
Subscriber Information

*First Name:
 *Last Name:
 *Birth Date: Must be: MM/DD/YYYY
 *Relationship: Spouse, Self, etc.
 *Address:
 *City:
 *State:
 *Zip:

I do not want the University Student Health Insurance Plan. I certify that I have comparable coverage as indicated above, which will be in force for the academic year.

I agree to the terms:

- You will be presented with a list of Insurance Companies. Search for your insurance company by entering in the first few letters of the name at the top of the screen in the field that says "Insurance Company Name" and change the drop down arrow from "begins with" to "Contains", then select "Look Up". Simply click on the Insurance Company Name and in the insurance company name will automatically populate in your waiver.



- If you can't locate your Insurance Company, search for "Other" and select that option. You will then need to enter the appropriate address information manually.

Look Up Insurance Co. List

Insurance Co. List:

Insurance Company Name:

[Basic Lookup](#)

Search Results

View 100 First 1 of 1 Last

Insurance Co. List	Insurance Company Name
OTHER	OTHER INSURANCE COMPANY - ADDRESS NOT REQUIRED

- Once your insurance company information has been entered, enter the "Subscriber Information" toward the right of the screen. This is the name, birth date, and relationship to you of the person whom the insurance policy is written for. This could be a parent, guardian, spouse or any other person whom carries you on their insurance. If you have your own insurance, simply enter your own name and birth date. To see a sample insurance card to help you with your waiver please [click here](#).

Subscriber Information

*First Name:

*Last Name:

*Birth Date: Must be: MM/DD/YYYY

*Relationship: ▼ Spouse, Self, etc.

*Address:

*City:

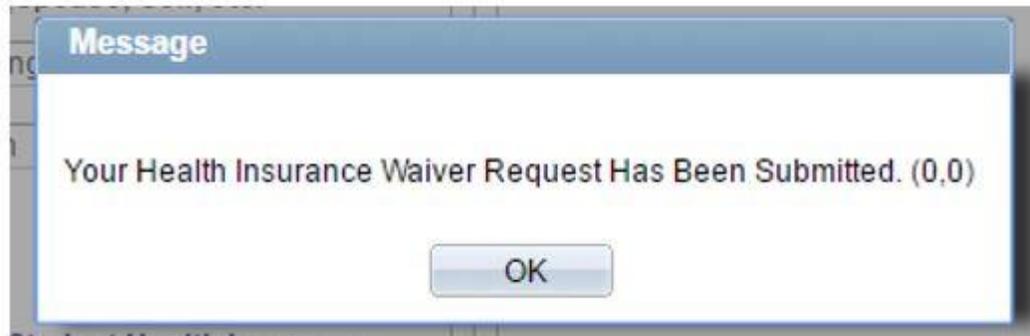
*State:

*Zip:

I do not want the University Student Health Insurance Plan. I certify that I have comparable coverage as indicated above, which will be in force for the academic year.

I agree to the terms:

- Once you have completed filling out this information, read the terms of the waiver and place a check box in the box following “I agree to the terms:”.
- Finally, click “**Submit Waiver**” in the lower right corner of the screen. A message will appear indicating your waiver has been submitted:



- You will receive a confirmation email at the address you specified in the waiver. Your waiver will be reviewed and approved/rejected within 30 days of submission. Please submit your waiver by the posted deadline to avoid purchasing the school sponsored health insurance.

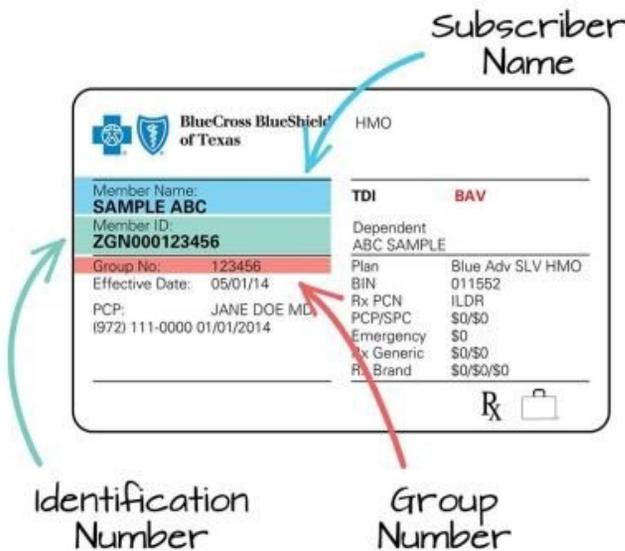
Should you have any questions, please contact us at 401-874-4774.

SAMPLE INSURANCE CARDS

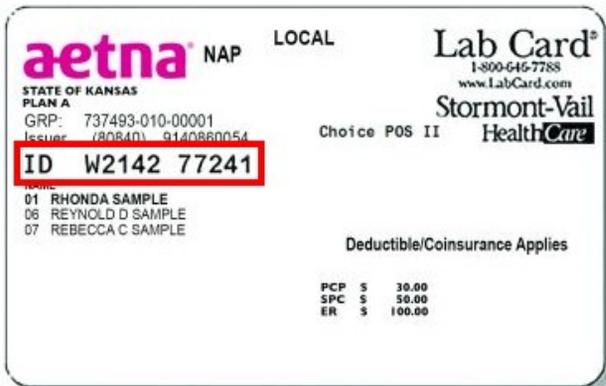
United Healthcare:



Blue Cross Blue Shield:

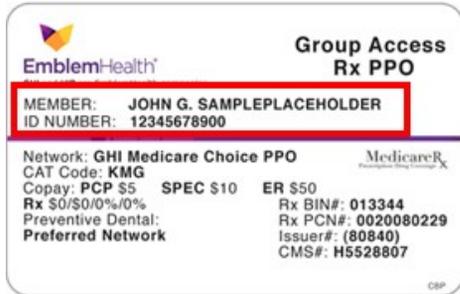


Aetna:



SAMPLE INSURANCE CARDS

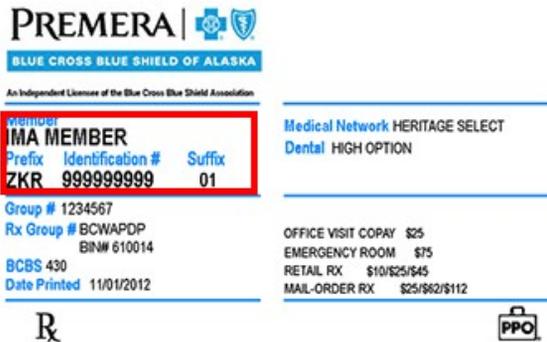
Emblem Health:



Kaiser Permanente:



Premera BCBS:



Tricare:



DoD ID Number – a 10-digit number that is NOT used for TRICARE
DoD Benefits Number (DBN) – an 11-digit number that may be used for TRICARE EDI claim submissions

SAMPLE INSURANCE CARDS

Harvard Pilgrim:


Harvard Pilgrim Health Care
 PLAN NAME
ID: H00000000-01
 Sample Name
 Eff. Date: 00/00/0000
 PCP: \$
 Specialist: \$
 Urgent Care: \$
 ER: \$
 RxBIN#: xxxxxx
 RxPCN#: xxxxxxxx
 RxGrp#: xxxxxx
 RxID#: xxxxxx
 DentalGrp#: <xxxxx>

 Hxxxx - PBP - <xxxx>

Medical Claims: HPHC Claims Dept. P.O. Box 151288 Tampa, FL 33684 EDI Payer ID: 64245
 Behavioral Claims: UBH P.O. Box 30760 Salt Lake City, UT 84130
 Dental Claims: Dental Claims P.O. Box 30567 Salt Lake City, UT 84130
Member Services: 888-609-0692
 TTY/TDD: 711 www.harvardpilgrim.org
 Dental Customer Service: 000-000-0000 Dental Providers: 000-000-0000
 Behavioral Health: 000-000-0000 Provider Services: 000-000-0000
 Pharmacy Technical Support: 000-000-0000
 Part D Prior Authorization: 000-000-0000



Cigna:


Open Access Plus
 Administered by Cigna Health and Life Insurance Company
 Medical/Rx
 Group 00999999
 ID 11111111
 PCP: None Selected
 No Referral Required
 Co-ins/Coinsurance
 Primary Care 10%
 Specialist 10%
 Urgent Care 10%
 RxBIN 017010 RxPCN 05180000
 RxGrp 00999999 RxID 11111111 00
 myCigna.com

Coventry Health Care:


PPO
 MEMBER NAME: xxxxxxxMEMBERxNAMExxxxxxx
 MEMBER NUMBER: xxMBRxBNR-x
 GROUP NUMBER: xxGRPxBNRx
 PLAN: xxxxxxPLANxTYPExxxxxx
 DATE OF BIRTH: xxx/xx/xxxx
 MEMBER RESPONSIBILITY:
 PRIMARY:OUTXX SPECIALTY:SPX DRUG:RXx
 ER:ERX HOSPITAL:INPOX UC:UCX
 Please refer to your Certificate of Coverage for coverage details.


Horizon Blue Cross



Product Name
 Horizon Blue Cross Blue Shield of New Jersey
 Member Name
J DOE
 Member ID Number
HFM3HZN12345678
 GROUP NUMBER 76026-0100
 EFFECTIVE DATE 05/01/2008
 BC/BS PLAN CODES 280/780
 CONTRACT TYPE FAMILY/TEFRA
 PCP NAME: JAMES JONES
 OFFICE VISIT \$15
 SPECIALIST \$25
 EMERGENCY ROOM \$100
 INPATIENT HOSP COPAY \$500
 RXBIN 004336
 RXPCN HZRX ISSUER (80840)
 RXGRP 0760260100
