THE AMERICAN UNIVERSITY of PARIS 50 YEARS

HEALTH EXEMPTION FORM

Must be returned to the Health Care Coordinator before the deadline

Family Name: ____________________

First Name: ____________________

AUP Number: ____________________

Phone Number: ____________________

Email: ____________________

Date of Birth: ________/______/______

☐ I would like to opt out from AUP's Insurance

ARE YOU ELIGIBLE TO OPT OUT?

	Status:	Question	Yes	No
☐	Visiting student	Do you have an own insurance which covers me in France for: coverage for at least 45,000 U.S. Dollars and include hospitalization, general medical treatment, medical repatriation and return of mortal remains ?		
☐	Degree Seeking Student **Over 28**	Do you have an insurance that covers in France?		
☐	Degree Seeking student Under 28	Do your parents live in Paris?		
☐	Degree Seeking student Under 28	Do you have an insurance that covers in France?		
☐	Part-time worker	Does the company you work for cover you for health?		

If you answer yes to the question(s) related to you, then you are eligible to opt out.

I have been informed that if I have not provided AUP with a valid proof of insurance, I will automatically be enrolled in the AUP Health Care Plan and will be charged €547 for the semester.

DATE: SIGNATURE:

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MANDATORY DOCUMENTS TO OPT OUT:

If you are eligible to opt out from AUP's Health Coverage, you still need to provide the following documents to opt out:

Visiting Student	Degree Seeking Under 28	Degree Seeking Over 28	Part Time Student who work
A proof of Insurance which must indicate • Coverage for at least 45,000 U.S. Dollars • Hospitalization • General medical treatment • Medical repatriation • Return of mortal remains **Must be written on the proof**	• A proof that your parents live in Paris (Phone/Gaz bill) • A valid proof of insurance • Insurance discharge signed by parents (see below)	• A valid proof of insurance	• A proof that you work • A proof that your company covers you

I have been informed that if I have not provided AUP with a valid proof of insurance, I will automatically be enrolled in the AUP Health Care Plan and will be charged €547 for the semester.

DATE: SIGNATURE:

MUST BE SIGNED BY PARENTS OF DEGREE SEEKING UNDER 28 ONLY

Paris, ……………………….

Sir/ Madam,

As an institution of higher education authorized to enroll our students in the French social security system for students, The American University of Paris has chosen to collaborate with a private insurance company (MSH - International) which provides complementary coverage in addition to French social security's basic coverage.

This additional insurance was designed and adapted with regard to the specific needs of our student population. With students from around the globe and often far from their families, AUP considers it our responsibility to ensure that each one of our students is adequately covered in case of need. This is why supplemental coverage has been mandatory since September 2010.

However, students with families in Paris may waive our supplement insurance by having their parents complete this form.

I hereby Mr. / Ms. _______________________ choose wittingly not to enroll _____________________ (Name of Student) in the complementary health coverage plan provided by The American University of Paris. I certify that I reside in Paris or the surrounding area and take full responsibility for the complementary health insurance of _____________________ (Name of Student). I understand that the American University of Paris relinquishes its responsibility for any problem related to the complementary health insurance of _____________________ (Name of Student) once this form is signed and validated.

Date : Signature :

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MUST BE SIGNED BY PARENTS OF DEGREE SEEKING UNDER 28 ONLY

Paris, le …………………….

Madame, Monsieur,

En tant qu'établissement d'enseignement supérieur privé habilité à affilier ses étudiants au régime de la sécurité sociale des étudiants, The American University of Paris a choisi de négocier avec une compagnie d'assurance privée (MSH International) une mutuelle complémentaire à la couverture sociale de base fournie par la caisse primaire d'assurance maladie.

Cette assurance complémentaire a été conçue et adaptée sur la base de l'expérience de notre institution pour ce qui concerne les besoins spécifiques de notre population estudiantine. Du fait de la diversité d'origine de nos étudiants et de leur éloignement de leur famille, AUP considère qu'il y va de sa responsabilité de s'assurer qu'en cas de besoin, la couverture de ses étudiants sera véritablement adéquate ; c'est pourquoi depuis septembre 2010, cette couverture complémentaire est obligatoire. Cependant, les étudiants installées à Paris (avec leur famille) qui souhaitent ne pas souscrire pourront être exemptées à condition que leurs parents remplissent le présent formulaire.

Je soussigné Mr/Mme________________________choisis en toute connaissance de cause de ne pas inscrire l'étudiant(e)______________________ à la mutuelle fournie par The American University of Paris. J'atteste qu'un de ses parents Mr/Mme_______________________se trouve sur la région parisienne et prend l'entière responsabilité de sa couverture maladie complémentaire. The American University of Paris décline toute responsabilité en cas de problème lié à la couverture complémentaire de cet(te) étudiant(e).

Date : Signature :