**HEALTH EXEMPTION FORM**



Must be returned to the Health Care Coordinator

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 for the semester.**

DATE: SIGNATURE:

**MANDATORY 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 | * 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 |

If you are eligible to opt out from AUP’s Health Coverage, you still need to provide the following documents 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 €540 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 :



|  |
| --- |
| 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 :