**HEALTH EXEMPTION FORM**

Must be returned to the Health Care Coordinator at health@aup.edu

Family name……………………………………………

First Name………………………………………………

AUP ID number……………………………………….

Email………………………………………………………

DOB: ..…./…..../………..……

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 (or close family) live in Paris?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 accordingly.**

DATE: SIGNATURE:

According to your status, please provide us with the adequate documents:

|  |  |
| --- | --- |
| STATUS | MANDATORY DOCUMENTS TO PROVIDE |
| Visiting students Coop students | A proof of insurance which must indicate: Coverage for at least 45,000 U.S. Dollars HospitalizationGeneral medical treatment Medical repatriation Return of mortal remainsHouse insurance (Civil Liability) |
| **Degree seeking** under 28 with family in Ile de France | Proof that student has a **family member who lives in Paris** A valid proof of insurance (Carte Vitale + Mutuelle)Exemption form signedHouse insurance (Civil Liability) |
| Degree seeking over 28 | Valid proof of insuranceHouse insurance (Civil Liability) |
| Student employed in France | Copy of your CDD/CDIProof that company covers the studentHouse insurance (Civil Liability) |

**IMPORTANT NOTES:**

**Coverage must be valid for the whole time that the student is here to study with dates clearly visible.**

**The deadline to receive an exemption from AUP health coverage is the last day of orientation week.**

**Any exemption that is approved must be updated every year so the student must apply for an exemption at the start of each academic year.**

|  |
| --- |
| MUST BE SIGNED BY PARENTS OF DEGREE SEEKING UNDER 28 ONLY |

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 :