

ATTORNEY GENERAL ANDREW M. CUOMO
STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL



STUDENT HEALTH INSURANCE COMPLAINT FORM

INSTRUCTIONS: Please complete this form and mail it, along with any supporting documentation that you have, to the New York State Office of the Attorney General, Bureau of Consumer Frauds & Protection, 120 Broadway, 3rd Floor, New York, New York 10271-0332. Please attach additional sheets, as necessary, to explain or supplement your answers.

1. Student's name: _____
2. Student's School Address: _____
3. Student's Home Address (if different than School Address):

4. Telephone: _____
5. Email: _____
6. For complaints filed by a parent or other family member of a student, please provide the name and contact information of the parent/ family member: _____

7. Student's school: _____
8. Student's health insurance provider: _____
9. Did school **require** you to purchase a particular school-endorsed health insurance plan, without providing the option of "waiving out" of the plan? _____
10. Did school require you to either purchase a school-endorsed health insurance plan or affirmatively "waive out" of such plan? _____
11. Was the school-endorsed health insurance plan completely voluntary (*i.e.*, no need to waive out)? _____
12. Did you have difficulty waiving out of your school's recommended health insurance? If yes, please explain. _____
13. Did you purchase the school-endorsed health insurance only because you did not understand that you had the option to waive out? _____

14. Did you encounter difficulties in obtaining or receiving reimbursement for medical treatment through your school's required or recommended health insurance? If yes, please explain.

15. Did your medical treatment costs exceed the limits of your school-endorsed plan?

16. Did you believe that the insurance you purchased through the school was a good plan because it was endorsed by your school? If yes, please explain. _____

17. Please share any other information you feel is relevant to your complaint.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL THE CONSUMER FRAUDS BUREAU AT 1- 800-771-7755.

PLEASE ATTACH TO THIS FORM **PHOTOCOPIES** of any documents you have to support your Claim. **DO NOT SEND ORIGINALS.**

The above statements are true to the best of my knowledge. I understand that any false statements made in this Claim Form are punishable as a Class A misdemeanor under Section 175.30 and/or Section 210.45 of the New York Penal Law.

Signature: _____ Date: _____

Print Name: _____