International Student Annual Insurance Waiver Request Form
Please read this document carefully
Submit this completed Waiver Form to the International Center, GSU 327

Name ___________________________________________ University ID # ________________

Please Print Clearly

Basis for Waiver Request

☐ I am requesting a Waiver from the University of Hartford Medical Insurance program because I am:

☐ Funded by my government, the U.S. government or an International Agency.

☐ Receiving health insurance benefits provided by a U.S. employer of my parent, spouse or domestic partner.

☐ Enrolled at the University but doing studies or research outside the U.S.

☐ Working in the U.S. and receiving health insurance benefits through my employer.

☐ I have other private health insurance that meets University and PPACA minimum requirements.

Insurance Information

Name of Insurance Company ____________________________________________________________

Is this a U.S. based Insurance company YES ___ NO ___

Policy Number ____________________________________________________________

Type of Insurance (Health/Dental/Vision) ________________________________

Amount of Coverage ______________________________________________________________

Start and End Date of Policy ________________________________

Insurance Company Address _________________________________________________________

Insurance Company Phone Number _________________________________________________

Name of Policy Holder and ID# ________________________________________________
Attestation

I request to WAIVE participation in the University of Hartford’s Student Medical Insurance Plan for the 20____-20____ academic/policy year. I understand that I am waiving coverage for the entire year and will not be able to enroll at a later date unless I lose coverage under my current health insurance plan.

I confirm that I am currently enrolled in a comparable student health insurance plan to that offered by the University of Hartford and that I will be continuously insured for the school year. I further acknowledge that by waiving the University Student Health Plan, I will be solely responsible for any medical expenses I may incur and neither the University of Hartford nor the AETNA will be held responsible for any medical expense incurred by me.

As an international student, I understand this coverage cannot be waived unless I am currently enrolled in a comparable insurance plan from a U.S. based insurance company.

I understand that a Waiver form must be submitted each academic year that I am enrolled as a student at the University of Hartford. I understand that as an international student, I may not waive the University of Hartford Student Health Insurance Plan unless I am covered by an insurance plan based in the United States that is comparable to the plan offered by the University of Hartford and meets minimum PPACA regulations. Note: Plans based in a U.S. territory (Guam, Virgin Islands, Puerto Rico) are not comparable and cannot be used to waive the university's insurance.

I further understand by submitting this form, I am granting permission for Gallagher Koster/University of Hartford to audit this information for documentation purposes. If the information provided on this form is found to be inaccurate/ fails to meet University and PPACA standards, I understand I will be required to be enrolled in the University of Hartford Student Health Plan and will be charged the full insurance premium.

Student Signature ____________________________________________ Date __________________________

Approved by: ____________________________________________ Date __________________________