

**International Student Health Insurance Waiver Form**

Name: \_\_\_\_\_ Student ID # \_\_\_\_\_

Please check one:  Undergraduate  Graduate  Pathway  ELI Visa Category: \_\_\_\_\_

**Please review this form carefully. Please initial or sign where indicated to confirm your understanding.**

**To be approved for an insurance waiver, you must provide proof of health coverage which meets the following criteria:**

- Coverage must begin on or before the first day of the academic term in which you are enrolled and extend through the entire term
- The insurance plan must be provided by a company licensed to do business in the US with a US claims office address, US claims phone number, and plan information available in English. (Short-term travel insurance does not qualify).
- No maximum benefit for the coverage (There can be no cap on the amount of coverage.)
- Deductible no greater than \$250/individual and \$500/family for in-network
- Co-insurance must be 20% or less
- No exclusions, including: pre-existing conditions, accidents, hospitalizations, ER visits, pharmacy benefits, pregnancy care, etc.
- The plan must provide inpatient and outpatient care in the Hartford, CT area. This includes office visits and mental health visits.
- Preventative and wellness visits covered at 100% with no co-payments
- Travel assistance for medical evacuation and repatriation
- Plan must be comparable to the Arthur J. Gallagher & Co./University of Hartford health insurance plan and be federally certified and compliant with the Patient Protection and Affordable Care Act (PPACA)

**If your health insurance plan fails to meet each of these requirements, you will be denied an insurance waiver and will remain enrolled in the University of Hartford's Health Insurance plan.**

**Insurance Information**

Policy Holder Name \_\_\_\_\_ Relationship to student \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

Member ID or Policy Number: \_\_\_\_\_

Effective Date \_\_\_\_\_ Termination Date: \_\_\_\_\_

**(Please attach a copy of the front and back of your insurance card)**

## International Student Health Insurance Waiver Form

I qualify for the waiver or cancellation under the following category:

- I am a sponsored student (Embassy or Government).  
*-Attach a copy of your letter of sponsorship and copy of your insurance card to this form*
- I am covered as a US based employee or dependent of a US based employee.  
*-Attach a copy of the health insurance card or other proof of coverage along with this form*
- I am enrolled in a PPACA (Patient Protection and Affordable Care Act) compliant plan as required by federal law that meets the University's minimum standards listed above.  
*-Attach a copy of the health insurance card or other proof of coverage along with this form*

I acknowledge that by submitting the health insurance waiver form, I am requesting to be waived out of the University of Hartford student health insurance plan and certify that (please initial each line):

\_\_\_\_\_ *I am currently enrolled in a health insurance plan that will remain in effect during my enrollment at the University.*

\_\_\_\_\_ *I have communicated with my health insurance plan carrier and determined that the benefits meet the minimum University of Hartford health insurance requirements, meet immigration requirements, and will adequately cover me during transit and during my stay in the US.*

\_\_\_\_\_ *I agree to pay for all medical expenses not covered by insurance. The University will not be held responsible for any medical expenses that I incur during my enrollment or during my stay in the US.*

\_\_\_\_\_ *I will notify the International Center if my insurance coverage changes or if it ends during the semester.*

\_\_\_\_\_ *I will promptly pay expenses incurred through my healthcare provider that are not covered by my policy, for example, copayments or deductible amounts.*

\_\_\_\_\_ *I must renew my health insurance waiver form each semester or at the end of my last waiver period, whichever comes first.*

I understand that information provided herein is confidential and will be used for the sole purpose of documenting my decision to waive the University of Hartford student health insurance. I am also granting the University of Hartford & Arthur J. Gallagher & Co. the permission to verify this information through an auditing process. I understand that the waiver approval or denial decisions are made at the sole discretion of the University. **If it is determined that the information provided on this form is invalid, I understand that I will be required to purchase a University approved student health insurance plan for that semester and for future, subsequent semesters.**

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

For Office Only:

Approved \_\_\_\_ Denied \_\_\_\_ Banner: \_\_\_\_ OM \_\_\_\_ OT Semester(s) \_\_\_\_\_