

# THE UNIVERSITY OF ALABAMA®

## International Student/Scholar Health Insurance Waiver Form for Fall 2017

**The Student or Scholar must complete the top section, sign, date and return it before 8/30/2017:**

UA STUDENT Campus Wide ID:	Telephone # with Area Code:	E-mail address:
Last Name:	First Name:	Middle Initial:
Street Address:		
City:	State:	Zip Code:

**Semester Starting Fall 2017:** Students who submit proof of comparable coverage by 8/30/2017 will be granted a one year waiver valid through 7/31/2018. If the Student cannot provide proof of comparable coverage through 7/31/2018, the student will be required to submit a waiver request to UA each semester. **NOTE: Students who lose coverage during the year must enroll through The University of Alabama's plan within 30 days of their loss of coverage, or otherwise wait until the next open enrollment period.**

I hereby authorize my health insurance company to release the following information to **The University of Alabama** located in Tuscaloosa, Alabama. I further understand that my failure to comply with these requirements on a timely basis will result in the cancellation of my participation in this waiver program.

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

**Your Health Insurance Company must complete the section on the form below:**

Sponsor or Policy Holder Name:	Policy Coverage Dates:	
Policy #	Company and Representative Name:	
Address:		
Telephone #:	Fax #:	E-mail Address:

**MINIMUM STANDARDS:** Please verify each standard is met by checking the appropriate box relative to the coverage provided. All of the following criteria **MUST** be met for the plan to be approved for a waiver by The University of Alabama:

**NOTE:** The University of Alabama assumes no responsibility for a student's medical expenses especially if they get a waiver from coverage.

**YES:      No:**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | This policy covers the person named above for <u>pre-existing medical conditions, unlimited annual, and unlimited dollar amounts for medical expenses</u> incurred outside the student's home country. |
| <input type="checkbox"/> | <input type="checkbox"/> | Standard co-insurance of 20% for In-Network or Participating Provider Organization (PPO).  |
| <input type="checkbox"/> | <input type="checkbox"/> | A deductible no greater than \$350 per person for in network (PPO) providers or \$750 per person for out of network (Non-PPO) providers for the policy's plan year.                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Coverage for repatriation of remains is equal to or greater than \$25,000. Medical evacuation coverage is equal to or greater than \$50,000.   |
| <input type="checkbox"/> | <input type="checkbox"/> | If there is a PPO requirement associated with the Plan's benefits, is there the availability of PPO hospitals and physicians in the greater Tuscaloosa, Alabama area?                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | The policy meets J Visa requirements as set forth by the Department of State. (For J Visa status)  |

The undersigned Insurance Representative **CERTIFIES** that all the information provided is correct.

Insurance Representative Title/Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**This waiver form must be received by mail or by fax directly to the following address before August 30, 2017.**

The University of Alabama Student Insurance Office  
 Student Health Center, Box 870360  
 Tuscaloosa, AL 35487

FAX: (205) 348-9571

OFFICE PHONE: (205) 348-4086