

F-1 INTERNATIONAL STUDENT INSURANCE WAIVER FORM

STUDENT MUST COMPLETE THIS PORTION OF THE FORM:

USA Jag ID#: _____ E-Mail Address: _____

Name: _____

Street Address: _____

City, State, Zip Code: _____ Telephone: _____

I have adequate health insurance coverage and request a waiver for the following semester(s):

- Fall Semester Spring Semester Summer Semester

I understand that I must complete a new insurance waiver form each semester or academic year, depending on my private insurance policy coverage dates. I understand that I will be automatically enrolled in the USA Student Health plan and will pay all relevant premiums for the period of time covered until USA receives and approves my verification of coverage. I understand that failure to maintain coverage may be cause for termination of immigration status. I hereby authorize my insurance company to release the following information to the University of South Alabama. I further understand that failure to comply with these requirements will result in the cancellation of my participation in the study program.

Student Signature: _____ Date: _____

INSURANCE COMPANY MUST COMPLETE THIS PORTION OF THE FORM:

Name of Insurance Company: _____		
Mailing address for claims: _____		
Telephone # _____	Fax# _____	E-mail address: _____
Sponsor or Policy Holder Name: _____		
Policy # _____	Group # _____	Coverage Dates: _____

Please verify **MINIMUM STANDARDS** by checking the appropriate box relative to the coverage provided. **ALL** of the following criteria **MUST** be met for the plan to be approved. Please check as appropriate (YES - coverage is provided, NO - coverage NOT provided):

- Yes No This policy provides both emergency and non-emergency health care and mental health care benefits of at least \$100,000 per accident or illness.
- Yes No A deductible no greater than \$500 per accident or illness.
- Yes No Coverage for repatriation of remains (a minimum of \$25,000 toward such expenses or, if an amount is not specified, the policy must specify coverage of all reasonable and necessary expenses for repatriation.)
- Yes No Medical evacuation coverage is equal to or greater than \$50,000.
- Yes No The claims administrator is based in the United States and has a US telephone number, address for submission of claims. *Students will be responsible for submitting their own claims.

The undersigned certifies that all information provided above is correct:

Insurance Representative Signature: _____ Date: _____

Printed Name: _____ Title: _____

E-Mail address: _____ Telephone: _____

This form must be received by mail/fax directly to the following address before the semester begins.

USA Student Health Center, Attn: Rhonda Baxter

5870 USA South Drive, Mobile, Alabama 36688

Office phone: 251-460-6022 Fax: 251-414-8227

E-Mail: rbaxter@southalabama.edu