

**THE UNIVERSITY OF ALABAMA®**  
**INTERNATIONAL STUDENT/SCHOLAR INSURANCE WAIVER FORM**

**STUDENT/SCHOLAR MUST COMPLETE THIS PORTION, INCLUDING SIGNATURE & DATE.**

<b>STUDENT ID:</b>	<b>TELEPHONE #:</b>	<b>E-MAIL ADDRESS:</b>
<b>LAST NAME:</b>	<b>FIRST NAME:</b>	<b>MIDDLE INITIAL:</b>
<b>STREET ADDRESS:</b>		
<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>
<b>SESSION:</b> <input type="checkbox"/> FALL 1, 2017 <input type="checkbox"/> FALL 2, 2017 <input type="checkbox"/> SPRING 1, 2018 <input type="checkbox"/> SPRING 2, 2018 <input type="checkbox"/> SUMMER 1, 2018 <input type="checkbox"/> SUMMER 2, 2018		

I hereby authorize my 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 program.

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

**Insurance Company must complete this portion of the form.**

<b>SPONSOR OR POLICY HOLDER NAME:</b>	<b>POLICY COVERAGE DATES:</b>
<b>POLICY #</b>	<b>COMPANY AND REPRESENTATIVE NAME:</b>
<b>ADDRESS:</b>	
<b>TELEPHONE #:</b>	<b>FAX #:</b>
<b>E-MAIL ADDRESS:</b>	

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:

Yes:    No:

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | This student policy meets all requirements mandated by the Affordable Care Act (ACA). (These requirements include unlimited lifetime dollar coverage, unlimited annual dollar coverage, and no waiting periods for pre-existing conditions.) |
| <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 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 CERTIFIES that all information is correct.*

Insurance Representative Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Please mail or fax directly to the following address BEFORE the first day of the ELI session:</b>		
English Language Institute – The University of Alabama		
Box 870250		
Tuscaloosa, AL 35487-0250	FAX: (205) 348-9266	OFFICE PHONE: (205) 348-7413