

# THE UNIVERSITY OF ALABAMA®

## International Student/Scholar Health Insurance Waiver Form Spring 2024

The Student/Scholar must complete the top section, sign, date and return by **1/31/24**

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

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 \$500 per person for in network (PPO) providers or \$1000 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: \_\_\_\_\_

<b>This waiver form must be received by mail or by fax directly to the following address by 1/31/24.</b>			
The University of Alabama Student Insurance Office			
Student Health Center, Box 870360			
Tuscaloosa, AL 35487	EMAIL: shc@ua.edu	FAX: (205) 348-0630	OFFICE PHONE: (205) 348-4086