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:	
☐	☐	This policy covers the person named above for pre-existing medical conditions, unlimited annual, and unlimited dollar amounts for medical expenses incurred outside the student's home country.
☐	☐	Standard co-insurance of 20% for In-Network or Participating Provider Organization (PPO).
☐	☐	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.
☐	☐	Coverage for repatriation of remains is equal to or greater than $25,000. Medical evacuation coverage is equal to or greater than $50,000.
☐	☐	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?
☐	☐	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 by 1/31/24.

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