



**University of Michigan-Flint
International Center**
219 University Center
303 East Kearsley Street
Flint, MI 48502-1950
Tel: 810-762-0867 Fax: 810-762-0006
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Health Insurance Waiver Request Form

This form should be used by F-1 students whose I-20 was issued by the University of Michigan-Flint. Information requested on this form will assist us in determining if your private or sponsor-provided health insurance meets University of Michigan standards for international health insurance. If it does, we will approve your insurance waiver request and cancel your enrollment in the International Student Insurance Plan (Chickering). Please keep in mind that the insurance will be cancelled effective the last day of the month the waiver was approved. . If your waiver is not approved, you will be required to keep the International Student Insurance Plan (Chickering). If you are on Post-Completion Optional Practical Training (OPT) contact the International Student Center.

Instructions:

1. Fill out the student information section of the **Insurance Information Sheet** and ask your insurance company representative to fill out the insurance company section. Please make sure they complete the box titled Insurance Company certification. **This section must be completed or your waiver request will not be accepted.** If your insurance company will not complete the Insurance Information Sheet they must provide a letter, on company letterhead confirming that your insurance policy meets **all** U-M standards listed on the Insurance Information Sheet. The letter must answer all of the questions, in detail that are listed on the Insurance Information Sheet. **If the questions are not completely answered, the waiver request will not be accepted.**
2. Fill out the *International Health Insurance Waiver Request Form* and attach:
 - The completed *Insurance Information Sheet*.
 - A copy of your insurance plan booklet in English.
 - Proof of enrollment in the insurance plan, such as a copy of your insurance card or your certificate of insurance. If your insurance plan covers your dependents, please also attach proof that they are covered by the plan.
3. Bring the form to the International Center, (IC). The IC will notify you if your waiver request is approved or denied within 14 days provided that the forms and attachments contain enough information to evaluate your waiver request.

International Health Insurance Waiver Request

Name: Family _____ First _____

UMID: _____ Birth date: Month _____ Day _____ Year _____

Gender: M F Email address: _____

Name of Insurance Company: _____

Policy Number: _____ Visa type: _____

Status: Graduate Student Undergraduate Student ELP Student

Requested Waiver Dates: From: _____ To: _____
(All waivers terminate on *August 31 of the current year*)

Are you the primary insurer under this policy? Yes _____ No _____

If you answered no to the above question, who is the primary insurer?

Name: _____

Relationship to student: _____

**The University of Michigan-Flint International Student Center
Insurance Information Sheet**

To be completed by the student:

By completing this section, you authorize your insurance company to provide University of Michigan-Flint with information regarding your insurance policy including verification of policy.

Your Name: _____

(Family or Last name)

(Given or First name)

Insurance Company: _____

Policy Number: _____

Date of birth: _____

m/d/yy

Your Signature: _____ Date: _____

To be completed by an insurance company representative:

The student listed above is seeking to opt out of the University of Michigan-Flint health insurance policy based on the policy they have with your company. Before the student can be released from our insurance they must first demonstrate the coverage with your company is comparable to what we offer. Please answer all of the questions below completely, including the certification section and supply any supporting materials. **Coverage for all requirements must be available in the U.S.** If you are unable to complete this document please provide a letter, on official company letterhead detailing the student's coverage. You can answer the questions through the letter. The letter must be attached to this information sheet.

Information about Coverage		
Is there a U.S. phone number for the insurance claims agent?	Yes <input type="checkbox"/> No <input type="checkbox"/> Phone number: _____	
Is this plan in full compliance with applicable federal law (specifically Title IX of Education Amendments of 1972, as amended by the Civil Rights Restoration Act of 1987)? Specific components of these laws include pregnancy treated as any other medical condition. <i>Insurance plans that exclude maternity coverage or severely limit it will not be accepted. Maternity coverage must be similar to coverage for other medical conditions.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
This Section: Any “yes” answers indicate that the coverage is <i>not</i> comparable to the International Student/Scholar Insurance Plan and therefore is <i>not</i> acceptable.	Does this insurance cover “ emergencies only ”?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Does this insurance pay for a patient’s condition to be “ stabilized ” but then require the patient to be returned to the home country for treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is this Travel Insurance? <i>Travel insurance is insurance that is in effect for a short period time (60 – 90 days, for example) and is designed for short trips. Insurance that you plan to substitute for the U-M International Student/Scholar Health Insurance Plan should be in effect at least through August 31 of the current academic year unless you plan to leave the University permanently before then.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is this coverage MediShare or another form of a cost-sharing arrangement that is not true medical insurance?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does this insurance plan provide medical benefits of US\$250,000 or more per accident or illness? <i>Please note that this amount must be available for accident or illness. For example, a plan paying up to \$125,000 for accident and \$125,000 for illness would not be acceptable.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does this insurance plan cover at least 80% of usual and customary charges in the Flint, Michigan area for hospital room, board, miscellaneous hospital expenses, and physician expenses in and out of the hospital, ambulance service, outpatient labs, x-rays, and diagnostic tests? <i>The plan may not contain specific limitations for the treatment of medical conditions relative to standard hospital or outpatient care. For example, an insurance plan that limited coverage of hospital room and board to \$500 or limited coverage of ambulance costs to \$350 would not be acceptable.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Does this insurance plan have a deductible of no more than \$100 per accident or illness, or \$150 per policy year?	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Does this insurance plan cover at least 90% of usual and customary charges for prescription drugs ?	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>Does this insurance plan cover both inpatient and outpatient mental health treatment and cover treatment for substance abuse (both alcohol and drug abuse)?</p> <p><i>A specific level of coverage for mental health treatment is not required. However, coverage for mental health treatment should not be significantly lower than the coverage provided by the U-M International Student/Scholar Insurance Plan. The U-M International Student/Scholar Insurance Plan covers inpatient mental health treatment for up to 30 days per policy year per condition. 25 visits per year for outpatient mental health treatment are covered with a co-pay of \$25 per visit (in network) or \$50/visit (not in network).</i></p>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<p>Does this plan must have a “medical evacuation to home country” benefit of at least \$10,000 and a “repatriation of remains” benefit of at least \$7,500?</p> <p><i>Note: If your plan meets all other requirements, you may purchase medical evacuation/repatriation coverage from the University of Michigan for \$30 per policy year (September 1 through August 31).</i></p>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Are there any differences between coverage for the primary insured and dependents? Yes No

If yes, please specify. _____

<p>Insurance Company Certification</p> <p>I hereby certify that all information on this form is complete and accurate, and that health insurance for the student and covered dependents (if any) listed above meets all requirements set forth above.</p> <p>Insurance Company Representative Name: _____</p> <p>Signature: _____ Date: _____</p> <p>Position or Title: _____</p> <p>Company Name: _____</p> <p>Telephone Number: _____ Fax Number: _____</p> <p>Email address: _____</p>	
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