



**International Center**  
219 University Center  
303 East Kearsley Street  
Flint, MI 48502-1950  
Email: IC@umflint.edu  
Phone: 810-762-0867 Fax: 810-762-0006

## Health Insurance Cancellation and Waiver Form

### For Students on Post-Completion Optional Practical Training (OPT) ONLY

The purpose of this form is to request cancellation of your International Health Insurance because you are now covered by insurance provided by your OPT employer. If your request is approved, a confirmation email will be sent to your UM-Flint email address for your records. If your request cannot be approved, you will be notified via your UM-Flint e-mail account.

#### REQUIREMENTS

- Attach a copy (front and back) of your new insurance card OR a letter from your employer's human resources department (on its letterhead) including the date your health insurance coverage began. *If you have F-2 dependents you must demonstrate that you have signed your entire family up for coverage.*

- Attach your Medical Evacuation/Repatriation Coverage Enrollment Form if you are enrolling in Medical Evacuation/Repatriation Coverage (**strongly recommended**). *In cases of extremely serious illness or death, this medical evacuation/repatriation coverage will pay reasonable and customary charges for medical evacuation or for the repatriation of mortal remains to the home country. The cost is \$30 per academic year (Sept. 1 through Aug. 31). Most insurance plans provided by employers do not include this coverage.*

- Fill out this form completely and sign. Return it via fax to 810.762.0006, email to mbarbee@umflint.edu, or mail to International Center, attn: Lynn Barbee, 303 E. Kearsley St., 219 UCEN, Flint, MI 48502-1950.

NAME		
First, Middle Initial	Uniqname:	UMID
INSURANCE COMPANY		
Name	Billing Address	Phone
COVERAGE		
Coverage start date	Id # / Contract # (include all numbers and letters)	Policy or group number

Please cancel all UM-Flint International Student/Scholar Health Insurance Plan coverage for me (and any dependents if applicable) effective \_\_\_\_\_ because I am covered by insurance provided by my employer as described above.

*NOTE: The effective date must be the last day of the month your new insurance began, unless your insurance started on the first day of the month, in which case you should enter the last day of the previous month. (For example, if your health insurance began on October 15, put "October 31" on the form. If your health insurance began on October 1, put "September 30" on the form.) If the International Center does not receive this form **within 60 days** of your new health insurance coverage start date, the effective date will be the last day of the month before the Center receives the form. (For example, if your insurance started September 21, but the International Center does not receive this form until February 21, the cancellation date will be January 31.)*

SIGNATURE		
Student Name	Signature	Date

---

**For Office Use Only: International Center approval:**

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