PLEASE READ REGARDING HEALTH INSURANCE WAIVER

- Health insurance waivers are for health insurance only. All students are required to maintain and pay for the Emergency Assistance & Evacuation insurance each semester.

- Approved fall 2016 waivers will be applied for both fall and spring semesters of the current academic year only. Additional academic years require submission of updated waivers.

- If you are an employee of the University (Graduate Assistant/Teaching Assistant/Lecturer), you do not need to submit a waiver application **EXCEPT** if you opt out the employee insurance.

- Travel insurance is not the same as health insurance and will not be accepted.

- Late fees if they relate to health insurance only may be removed until determination of your waiver application. All tuition and other charges including Emergency and Evacuation insurance must be paid. If your waiver is denied, any future late payment fees occurred will be your responsibility.

HEALTH INSURANCE WAIVER INSTRUCTIONS

<table>
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<tr>
<th>STEP 1</th>
<th>Review your current policy. Benefits must meet minimum qualifications listed on Verification of Insurance Policy Benefit Form attached.</th>
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<tr>
<td>STEP 2</td>
<td>Complete International Health Insurance Waiver Form attached.</td>
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<td>STEP 3</td>
<td>Send Verification of Insurance Policy Benefits to your insurance company for completion.</td>
</tr>
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<td>STEP 4</td>
<td>Sign and send both completed forms to Health Insurance Coordinator by October 15th.</td>
</tr>
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<td>STEP 5</td>
<td>Wait. Review of applications begins August 15th. Please allow 3-4 weeks for processing.</td>
</tr>
</tbody>
</table>

**IF WAIVER IS APPROVED:** The Office of Student Accounts will remove your health insurance charges. If you have paid for the health insurance, you will receive a refund for this amount.

**IF WAIVER IS DENIED:** You will receive an email notification from the Health Insurance Coordinator for explanation of denial. Payment for the health insurance will be required. Any additional late payment fees will be your responsibility.
INTERNATIONAL HEALTH INSURANCE WAIVER

TERM(s): ☐ FALL ☐ SPRING ☐ SUMMER ☐ Academic YR to

Health Insurance waiver application must be completed prior to October 15th for fall students and February 15th for new students starting for the spring Semester.

PLEASE COMPLETE THE FOLLOWING STUDENT INFORMATION:

STUDENT NAME: __________________________    _______________________   ____________________________

First                  Middle/Initial                  Last

UALBANY ID (000 or 001): _______ - _______ - _______  GENDER: ☐ Male ☐ Female  VISA TYPE: _____________

DATE OF BIRTH (MM/DD/YYYY) ______________________  Home Country: _________________________________

UALBANY EMAIL: ____________________________________  PHONE: _________________________________

LOCAL ADDRESS: ________________________________________________________________________________

CITY, STATE, ZIP CODE ________________________________________________________________________________

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: __________________________________________________________________

INSURANCE COMPANY PHONE NUMBER: ________________________________________________________________

INSURANCE Policy or Certificate Number Issued To You: ________________________________________________

EFFECTIVE DATE OF YOUR INSURANCE (MM/DD/YYYY): ________________________________________________

TERMINATION DATE OF YOUR INSURANCE (MM/DD/YYYY): ________________________________________________

I certify that my current health insurance coverage meets or exceeds the above listed minimum coverage. I understand that the sole purpose of SUNY’s review of this information is to determine if I qualify for a waiver of enrollment in the Student Health Insurance Plan. I understand that SUNY’s review and/or approval of this application does not constitute a determination by SUNY as to the adequacy of this coverage for any purpose. I certify that my health insurance coverage is in effect and will remain in effect for the entire coverage period for which I am requesting this waiver. I certify that I am legally responsible for my own medical expenses and that SUNY is not responsible for such expenses and fully agree to hold harmless the “University”.

Student Signature ____________________________________________  Date __________________________

Please bring this completed form along with the Insurance Verification Form that is to be completed and signed by your insurance company to your campus representative.
VERIFICATION OF INSURANCE POLICY BENEFITS

This form should be completed and signed by a representative of your insurance company. You must also sign the acknowledgment at the bottom of the form and return completed form to your campus representative.

Student Name: ____________________   ____________________   ___          School ID #: ____________

Last Name     First Name     MI

NAME OF INSURANCE COMPANY______________________________________________________________

All monetary units must be expressed both in the relevant foreign currency and in U.S. dollars at the current exchange rate.

Effective dates of coverage: _____/_____/______ through _____/_____/______

1. Annual Maximum Benefit Per Injury or Sickness Foreign: ___________ USD: ___________
   $300,000 minimum required to obtain waiver

2. Deductible amount Foreign: ___________ USD: ___________

3. Maximum daily benefit for In-hospital room & board Foreign: ___________ USD: ___________

4. Is Medical Evacuation covered? Yes _____ No _____
   To what amount? Foreign: ___________ USD: ___________

5. Is Repatriation covered? Yes _____ No _____
   To what amount? Foreign: ___________ USD: ___________

6. Are Outpatient Emotional and Mental Disorders covered? Yes _____ No _____
   Required to obtain waiver-minimum 30 visits
   To what amount? Foreign: ___________ USD: ___________

7. Are Inpatient Emotional and Mental Disorders covered? Yes _____ No _____
   Required to obtain waiver-minimum 30 visits
   To what amount? Foreign: ___________ USD: ___________

8. Is Outpatient Alcoholism and Substance Abuse covered? Yes _____ No _____
   Required to obtain waiver
   To what amount? Foreign: ___________ USD: ___________

9. Are Prescription Drugs covered? Yes _____ No _____
   Required to obtain waiver
   To what amount? Foreign: ___________ USD: ___________
VERIFICATION OF INSURANCE POLICY BENEFITS

10. Are Pre-Existing Conditions covered? Yes _____ No _____

Required to obtain waiver

Is there a Waiting Period - Number of Months: ________________

Has it been met? Yes _____ No _____

11. Suicide/Self-Inflicted Injuries covered? Yes _____ No _____

Required to obtain waiver

12. Doctor Office Visits at 100%? Yes _____ No _____

13. Plan will pay providers directly for doctor
Office visits and inpatient services

Required to obtain waiver

Representative Name (PRINT) ___________________ Represented Signature ___________________ Phone Number ___________ Date ___________

I take full responsibility for the answers I have supplied above, and fully agree to hold harmless (College/University Name) for any incorrect translation or medical expenses I may incur due to the limitations of my private health insurance coverage. I give permission for enrollment and benefit information to be released to ___________________ for the purpose of attempting an insurance waiver and to file for statistical use and use of the participant for medical reasons.

Policy Holder’s Signature ___________________ Date ___________ Policy Holder’s Email Address ___________________

Per the State University of New York, all of the above requirements must be met in order to obtain a successful waiver. Upon completion, please return this form to the Insurance Coordinator at the Office of International Education at the University at Albany by October 15th for Fall semester and February 15th for new students starting for Spring semester.

Please send both Verification of Insurance Policy Benefits and International Health Insurance Waiver by mail or email to:

Insurance Coordinator
University at Albany
International Education SL G40
1400 Washington Ave
Albany, NY 12222

Intinsurance@albany.edu