**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 2015 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

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

**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.**

UNIVERSITY AT ALBANY
State University of New York

# 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 Yes _____ No _____
**Required to obtain waiver**

_____ _____ _____ _____/_____/_____
Representative Name (PRINT) Representative 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**