



**The University of Michigan-Dearborn
Counseling & Support Services**

2157 University Center
4901 Evergreen Rd
Dearborn, MI 48128-1491
Tel: 313-593-5430 Fax: 313-593-3263
Email: counseling@umd.umich.edu

**International 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 Plan (Aetna) because you are now covered by insurance provided by your OPT employer. You will be notified via **your U-M email** if your waiver request is approved or denied.

Instructions:

1) Attach a copy (front and back) of your new insurance card OR a letter from you 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.

2) 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 August 31). Most insurance provided by employers does not include this coverage.

3) Fill out this form completely and sign. Return it via fax to 313-593-3263 or mail to University of Michigan – Dearborn, Counseling & Support Services, 2157 UC, 4901 Evergreen Rd, Dearborn, MI 48128-1491.

Note: If your employer is the University of Michigan, you are still required to fill out this form and return it to Counseling & Support Services, C&SS. Once completed, C&SS will approve your waiver form and cancel your enrollment in the International Health Insurance Plan (Aetna).

Section A: Cancellation Request

Name: _____
Last First

UMID: _____ Date of Birth: _____

UM-D email address: _____

Names and Dates of Birth of Insured Dependents:

Please cancel all U-M International Student/Scholar Health Insurance Plan (Aetna) coverage for me (and any dependents if applicable) effective _____ because I am covered by insurance provided by my employer as described below:

Note: The effective date must be the last day of the month your new insurance began, unless your insurance started on the first business day of the month, in which case you should enter the last day of the previous month. (For example, if you start work on October 15, put "October 31" on the form. If you start work October 1, put "September 30" on the form.)

If Counseling & Support Services (C&SS) does not receive this form **within 60 days** of the coverage start date, the effective date will be last day of the month before C&SS receives the form. (For example, if your insurance started September 21, but C&SS does not receive this form until February 21, the cancellation date will be January 31st.)

Section B: Insurance Company Information

Insurance Company Name: _____

Insurance Company Billing Address: _____

Insurance Company Phone: _____ **Coverage Start Date:** _____

ID# / Contract # (include all letters and numbers): _____

Policy or Group number: _____

Your Signature: _____ Date: _____