



**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 Waiver Request Form

*This form should be used by F-1 students and J-1 students or scholars whose Forms I-20 or DS-2019 were issued by the University of Michigan-Dearborn. The purpose of this form is to gather information about your private or sponsor-provided health insurance so that we can determine whether or not it 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/Scholar Insurance Plan (Aetna). You will be notified via **your U-M email** if your waiver request is approved or denied. If you are on Post-Completion Optional Practical Training (OPT) use [OPTWaiverForm.pdf](#).*

Instructions:

- 1) Fill out the student/scholar information section of the *Insurance Information Sheet* and ask your insurance company representative to fill out the insurance company section, or to attach a letter to the *Insurance Information Sheet* confirming that your insurance policy meets **all** U-M standards listed on the *Insurance Information Sheet*.
- 2) Fill out the *International Health Insurance Waiver Request Form* (this 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 or a letter from your insurance company stating that you are covered by the plan. If your insurance plan covers your dependents, please also attach proof that they are covered by the plan.
- 3) Return this form and all supporting documentation to Counseling & Support Services, C&SS (2157 University Center). You will notify via email 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.

Name: _____
Last First

UMID: _____ **Birth date:** _____ (mm/dd/yyyy) **Gender:** M F

Email address: _____

Names and Dates of Birth of Insured Dependents:

Name of Insurance Company: _____ **Policy Number:** _____

Visa Type: _____ **Status:** Graduate Student Undergraduate Student Visiting Scholar

Requested Waiver Dates: From: _____ **To:** 08/31/10 or _____
(all waivers terminate on August 31 of the current year)

Type of coverage: Self Self + Spouse Self + 1 child Self +2 or more in family

If your coverage is provided by a family member:

Name: _____ **Identification Number:** _____

Relationship to Insured: _____

➔ **Continued from previous page.**

<p>Does this insurance plan provide medical benefits of US\$1,000,000 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 \$500,000 for accident and \$500,000 for illness would not be acceptable.</i></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover at least 80% of usual and customary charges in the Dearborn, Michigan area for hospital room, board, miscellaneous hospital expenses, 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></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does the insurance plan have a deductible of no more than \$100 per accident or illness, or \$150 per policy year?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover at least 90% of usual and customary charges for prescription drugs?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover both inpatient and outpatient mental health treatment and cover treatment for substance abuse (both alcohol and drug abuse)? <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>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<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? <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>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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

If yes, please specify. _____

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