

**CSU APPLICATION FOR HEALTH INSURANCE WAIVER
INTERNATIONAL STUDENTS ONLY**

Should you have questions about completing this form, please call us at (970) 491-7121.

Your health is important to us and critical to your success at CSU. The waiver process is designed to assist you in selecting a health insurance plan that will assist with your medical expenses should you have an accident or sickness and one that also complies with the United States Health Care Reform insurance laws.

International Students applying for a CSU student insurance waiver should complete this form and return it to the Business Services office at the CSU Health Network, second level, or email it to CSUHN_Insurance@colostate.edu
NO LATER THAN September 6, 2017.

Waivers may be approved for the following types of insurance plans:

- Employer Group Health Plans with acceptable deductible levels
- Sponsored Health Insurance Plans approved through the Office of International Programs
- Individual Health Insurance Plans that meet Health Care Laws

Documentation required for approval:

- Employer Group Plans:** Complete section A and provide a copy of the front and back of your current insurance ID card.
- Individual Health Plans:** Complete sections A and B and provide a copy of the front and back of your current insurance ID card.

****For INDIVIDUAL PLANS, please provide the insurance plan document listing all benefits and exclusions of the policy**

Waivers will not be approved for the following type of insurance plans:

- Short term in-bound travel policies/ policies not written in english/ policies without benefits listed in U.S. dollars
- Short term/ limited duration/sickness and accident insurance plans
- Foreign insurance plans with U.S. affiliates/representatives or reimbursement programs
- Health insurance plans that do not meet health care laws

SECTION A : Student Information

Are you an International Student? YES NO If no - please call 491-7121

LAST NAME FIRST NAME MI STUDENT ID # DATE OF BIRTH

CURRENT ADDRESS CITY STATE ZIP

EMAIL ADDRESS

PHONE NUMBER

PLEASE PROVIDE THE FOLLOWING:

SELECT TYPE OF PLAN: INDIVIDUAL EMPLOYER GROUP PLAN

IF THIS IS AN EMPLOYER GROUP HEALTH PLAN PLEASE PROVIDE THE NAME OF THE EMPLOYER

NAME OF THE INSURANCE PROVIDER

INSURANCE COMPANY PHONE NUMBER

NAME OF THE PRIMARY INSURED

RELATIONSHIP TO PRIMARY INSURED SELF PARENT SPOUSE

HOW LONG HAVE YOU BEEN COVERED UNDER YOUR CURRENT MEDICAL PLAN?

SECTION B : Health Insurance Information - Please provide the following information about your health insurance:

WAIVER CRITERIA (please answer the following questions and provide page numbers from your attached policy.)

Does your plan provide for each of the following:

	YES	NO	PAGE NUMBER
1) Unlimited Sickness or Accident Benefit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
2) No Lifetime Maximum amount on the following Health Benefits:			
Preventive and Wellness Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Prescription Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Outpatient Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Emergency Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Maternity and Newborn Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Laboratory Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Chronic Disease Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
3) Mental/behavioral health and substance use disorder services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
4) No pre-existing condition waiting period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
5) Co-insurance: 80% insurance/ 20% your responsibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

International students, per Federal Visa requirements, must have these **ADDITIONAL** benefits in their insurance plan:

(<http://j1visa.state.gov/sponsors/how-to-administer-a-program/>)

	YES	NO	PAGE NUMBER
1) No greater than a \$500.00 deductible per person *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
2) Minimum of \$25,000 in repatriation benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
3) Minimum of \$50,000 in medical evacuation benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

*A deductible is what you pay out of your pocket before the insurance starts to pay

You will be notified via email once your waiver has been processed. Please allow 10 business days for processing.

If there is other relevant information you would like us to know about your health policy, please provide it here:
