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 selecti insurance plan that will assist with your medical expenses should you have an accident or sickness and one that also cor 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 Busine office at the CSU Health Network, second level, or email it to CSUHN_Insurance@colostate.edu

NO LATER THAN January 31, 2018.

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 car**

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 you plan provide for each of the following:

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

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 NUMB
1) No greater than a $500.00 deductible per person *			
2) Minimum of $25,000 in repatriation benefits			
3) Minimum of $50,000 in medical evacuation benefits			

***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:

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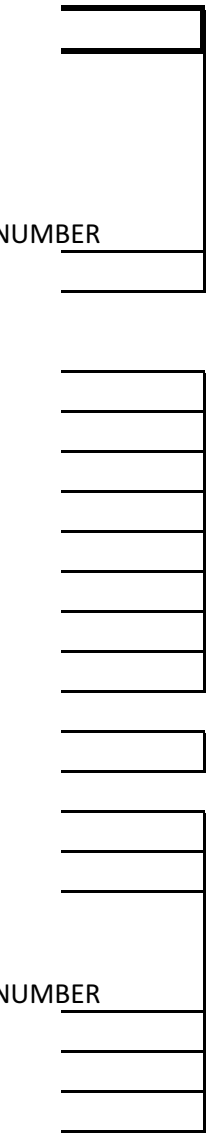
nplies with

ess Services

d. Individual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