UNIVERSITY OF SOUTH ALABAMA

F-1 INTERNATIONAL STUDENT INSURANCE WAIVER FORM

STUDENT MUST COMPLETE THIS PORTION OF THE FORM:

USA Jag ID#: _____ E-Mail Address: _____
Name: _____
Street Address: _____
City, State, Zip Code: _____Telephone: _____

I have adequate health insurance coverage and request a waiver for the following semester(s):
☐ **Fall Semester** ☐ **Spring Semester** ☐ **Summer Semester**

I understand that I must complete a new insurance waiver form each semester or academic year, depending on my private insurance policy coverage dates. I understand that I will be automatically enrolled in the USA Student Health plan and will pay all relevant premiums for the period of time covered until USA receives and approves my verification of coverage. I understand that failure to maintain coverage may be cause for termination of immigration status. I hereby authorize my insurance company to release the following information to the University of South Alabama. I further understand that failure to comply with these requirements will result in the cancellation of my participation in the study program.

Student Signature: _____ Date: _____

INSURANCE COMPANY MUST COMPLETE THIS PORTION OF THE FORM:

Name of Insurance Company: _____
Mailing address for claims: _____
Telephone # _____ Fax# _____E-mail address: _____
Sponsor or Policy Holder Name: _____
Policy # _____ Group # _____ Coverage Dates:_____

Please verify MINIMUM STANDARDS by checking the appropriate box relative to the coverage provided. ALL of the following criteria MUST be met for the plan to be approved. Please check as appropriate (YES - coverage is provided, NO - coverage NOT provided):

__Yes __No This policy provides both emergency and non-emergency health care and mental health care benefits of at least $100,000 per accident or illness.
__Yes __No A deductible no greater than $500 per accident or illness.
__Yes __No Coverage for repatriation of remains (a minimum of $25,000 toward such expenses or, if an amount is not specified, the policy must specify coverage of all reasonable and necessary expenses for repatriation.)
__Yes __No Medical evacuation coverage is equal to or greater than $50,000.
__Yes __No The claims administrator is based in the United States and has a US telephone number, address for submission of claims. *Students will be responsible for submitting their own claims.

The undersigned certifies that all information provided above is correct:
Insurance Representative Signature: _____ Date: _____
Printed Name: _____ Title: _____
E-Mail address: _____ Telephone: _____

This form must be received by mail/fax directly to the following address *before* the semester begins.
USA Student Health Center, Attn: Rhonda Baxter
5870 Alumni Drive, Mobile, Alabama 36688
Office phone: 251-460-6022 Fax: 251-414-8227
E-Mail: rbaxter@southalabama.edu