

REQUEST FOR STUDENT INSURANCE WAIVER

NAME: _____ BU ID#: _____

VISA TYPE: _____ E-MAIL: _____

WAIVER: FALL SPRING SUMMER YEAR: _____

PLEASE CHECK YOUR REASON FOR REQUESTING A WAIVER:

1. ____ GRADUATING AT END OF SPRING SEMESTER (**For waiver of summer insurance only**) You must have filed for graduation or show that your J-1 program ends as noted on your DS-2019.

2. ____ OTHER HEALTH INSURANCE _____

A student whose family or employer already provides health insurance may be eligible to qualify for a waiver. Proof of insurance is necessary. **The alternate policy must already be in effect before first enrollment period at Baylor University.** To qualify for a waiver of Baylor University Student Insurance your policy must meet or exceed the following minimum requirements.

- Student is covered by a U.S. employer health insurance plan that is compliant with the Affordable Care Act (ACA).
- Student is covered by a parent/spouse's U.S. employer health insurance plan that is compliant with the Affordable Care Act (ACA).
 - o *Please note: travel plans or plans that require you to pay for treatment yourself and then apply for reimbursement WILL NOT be acceptable for waiving the Baylor University Student Health Plan.*

- A. \$500 OR LESS DEDUCTIBLE (PER POLICY PER INSURED)
- B. UNLIMITED MAXIMUM BENEFIT PER POLICY YEAR
- C. \$7,500 MINIMUM REPATRIATION BENEFIT*
- D. \$10,000 MINIMUM MEDICAL EVACUATION BENEFIT*

***If your policy otherwise meets University standards but does not provide coverage for items C and D, you will be required to enroll in the Global Medical Services, and your student account will be charged.**

https://www.academichealthplans.com/docs/Assist_America_Brochure.pdf

3. ____ For family or employer provided insurance, you must provide:

- A. A Recent pay statement or letter from your company verifying current employment and a copy of your insurance enrollment card, and
- B. Either a copy of the policy pages which detail coverage categories and amounts of coverage in English, **or** a letter from your sponsor or insurance company stating your insurance coverage meets or exceeds the above listed minimum coverage as indicated by items A, B, C, and D.

I certify that my current health insurance coverage meets or exceeds the above listed minimum coverage as indicated by items A, B, C, & D

Signature: _____ Date: _____

NOTE: No waiver of insurance can be processed after the 12th class day of the long semesters or 4th class day of each summer session. No insurance refunds will be granted after 12th or the 4th class days. ⁱ