



OFFICE OF INTERNATIONAL PROGRAMS

F-1 STUDENT HEALTH INSURANCE WAIVER APPLICATION STUDENT ACKNOWLEDGMENT & INSURANCE PROVIDER CERTIFICATION FORM

Section A must be completed by student

A

Last Name, First Name

Student ID#

Birthdate (mm/dd/yyyy)

I acknowledge that Salve Regina University (SRU) policy requires international students to provide evidence of all-inclusive health insurance while registered at the University. I acknowledge that it is my responsibility to choose my own health insurance carrier and to obtain the carrier's certification that the plan meets specific minimum coverage requirements. **Please read all of the terms, conditions and exclusions first before purchasing any other product.** I further acknowledge my responsibility to maintain insurance coverage and to submit this form at each and every renewal or change of carrier. Further, I understand that the SRU required minimum coverage levels may change each year and that I am responsible for updating my insurance in keeping with the stated requirements.

I certify that I am covered by all-inclusive health insurance as described below. I promise to maintain this level of health insurance throughout the time I am registered at SRU. I acknowledge and agree that SRU is not responsible for my health insurance or medical expenses. If I have dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

Student Signature

Date

email address



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Section B must be completed by the health insurance company representative:

Name(s) of insured individual(s):

B
Print Full Name Print Full Name

Insurance Carrier:

Member Insurance ID#: Dates*: to
mm/dd/yyyy mm/dd/yyyy

*While enrolled at SRU, you are required to have all-inclusive health insurance.

The plan/policy must meet ALL of the following minimum coverage requirements (all amounts are in USD).
Agent: initial each line that meets coverage requirements.

_____ Health insurance coverage must be **UNLIMITED** per accident/illness

\$ _____ Medical maximum per incident/illness/injury if not unlimited

_____ Your plan must provide medical benefits (doctor visits, hospital, surgery, laboratory tests, x-rays, etc.) for each accident or illness.

_____ Inpatient/Outpatient medical/surgical coverage in Rhode Island
Your plan must pay for covered medical expenses in Rhode Island (including mental health, substance abuse and alcohol related illness or injury) for both inpatient (stay at an inpatient facility/hospital) and outpatient (doctor's office, outpatient department of a hospital or ambulatory surgery center) services.

_____ Inpatient/Outpatient mental health, substance abuse and alcohol related illness or injury coverage in Rhode Island

_____ Repatriation coverage must be at least \$25,000 USD
Your plan must provide at least \$25,000 USD to send your body/remains back to your home country.

_____ Medical evacuation coverage to home country must be at least \$50,000 USD

_____ No more than \$1,500 USD deductible per policy year

_____ No waiting period for pre-existing conditions
Your plan cannot exclude coverage for any pre-existing conditions.

_____ Headquartered and operating in the U.S. with a U.S. claims address and customer service telephone number

**I certify that the minimum coverage requirements stated above are provided by this policy/plan.
I am qualified to make this determination as an authorized agent/employee of the above insurance provider.**

Underwritten by: _____ Rating: _____

Print Name Contact Information (email and/or phone number) Company/Agency

Signature Title Date



OFFICE OF INTERNATIONAL PROGRAMS

F-1 STUDENT HEALTH INSURANCE - INADEQUATE WAIVER COVERAGE

To be completed by student

C

Last Name, First Name	Student ID#	Birthdate (mm/dd/yyyy)
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If your insurance provider is unable to guarantee all of the coverage details on page 2 (Section B of this form), then the plan you have chosen does NOT meet all the qualifications and you must complete this section.

In order for Salve Regina to accept your waiver, you must agree to the following:

1. I certify that I understand that my chosen medical insurance does not cover all the qualifications for the waiver
2. I accept and understand that this could result in incurring substantial out-of-pocket costs for medical care
3. I agree to maintain this level of health insurance throughout the time I am registered at SRU.
4. I acknowledge and agree that SRU is not responsible for my health insurance or medical expenses. If I have dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

Student Signature	Date
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