# 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

*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.**

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

_____
**Signature** **Title** **Date**