SHI WAIVER APPLICATION CHECKLIST

Attention Students:

It is your responsibility to make sure that you have read and understand the information that is listed on the checklist and waiver application form. The SHI Office will not accept incomplete applications and will not make any exceptions for accepting waiver applications before or after the scheduled dates of the waiver period. Please follow the steps below to ensure that you will not be submitting an incomplete waiver application.

Bring this checklist form with you when you submit your application in the Student Health Center. The Staff will give this page back to you and this page will serve as your receipt that we have received your application.

☐ Read and complete the attached waiver application.
☐ Verify that your policy meets the following minimum UT System requirements:
   1. Medical Coverage is $50,000 or more PER ACCIDENT/ILLNESS
   2. Deductible is $500 or less
   3. Medical Evacuation Coverage is $10,000 or more
   4. Repatriation Coverage is $7,500 or more
   5. Company: meets federal solvency guidelines (if you are unsure, you may ask your insurance company)
   6. Dates of coverage meet or exceed the requirement for the semester

☐ Attach all of the required documentation that is listed for your section on the application.
☐ Submit your waiver application in person to the Student Health Center (SSB 4.700) or by email.
☐ The Student Health Insurance Office will process waivers within a maximum of five business days.
☐ The Student Health Insurance Office will send all communication through your UTD email address only.
☐ Complete waiver application should be submitted ONLY ONCE unless otherwise instructed.
☐ All documents must be in English.
☐ All documents that list any form of currency must be in U.S. dollars.
☐ If the documents are in a foreign language, a certified translation will be required with your application.
☐ Copies of the entire benefits guide will no longer be accepted; only the summary page is required.
☐ Incomplete waiver applications will not be reviewed.
☐ Multiple semester waivers will be given for the current academic year only and only if the coverage dates of your policy include the dates of the semesters for which you are making application.
☐ Waiver applications will only be accepted during the scheduled waiver period dates.

This is to certify that the Student Health Insurance Office has received a complete waiver application from

__________________________________ ______________________ for the _______________ semester(s).

Name                                  UTD ID

SHC Staff Use Only/Date: ______________________

You will receive a decision on your waiver application no more than 5 business days from the date of this receipt.

Revised 04/25/2011
Student Health Insurance Waiver Application
Based on a Private Insurance Policy

Student Name__________________________________________ Date of Birth: ________________
UTD Email: _____________________________________________ Visa Type: ________________
UTD ID: ________________________________________________

Semester(s) for which the waiver is requested:
☐ Spring 2013 (1/14/2013-5/29/2013)
☐ Summer 2013 (5/30/2013-8/18/2013)

Part 1:
In support of my request for a waiver from the requirement that I enroll in the Student Health Insurance Plan, I certify that I have current health insurance coverage that meets or exceeds the following requirements that will remain in effect for the entire UTD Student Health Insurance coverage period:

☐ Yes ☐ No $50,000 or more medical benefits for each illness or injury.
☐ Yes ☐ No A deductible of $500 or less.
☐ Yes ☐ No Minimum of $7,500 for repatriation of remains benefit.
☐ Yes ☐ No Minimum of $10,000 for medical evacuation benefit.

In support of my request, I am providing the following required documentation to verify (1) my coverage meets or exceeds the required minimums listed above and (2) the coverage will remain in effect during the period for which the waiver is requested:

☐ A copy of my benefits summary, in English, that identifies me as a covered individual, provides the dates of my coverage, and clearly indicates that the coverage meets or exceeds the minimum requirements, including coverage amounts in US dollars.
☐ A copy of the front and back of my insurance card.
☐ A copy of proof of medical evacuation and repatriation coverage, if applicable.

Part 2:
ATTENTION STUDENTS: PLEASE READ THROUGH THE FOLLOWING INFORMATION AND PUT YOUR INITIALS IN THE BLANK SPACES NEXT TO EACH STATEMENT. IT IS YOUR RESPONSIBILITY TO MAKE SURE THAT YOU HAVE READ AND UNDERSTAND THIS ENTIRE FORM.

PLEASE INITIAL BELOW:

☐ The SHI Office will process waivers within a maximum of five business days from the date the application is received.
☐ The SHI Office will send all communication through my UTD email address only.
☐ All documents must be in English and any form of currency must be in U.S. dollars.
☐ If the documents are in any language other than English, a certified translation will be required with your application.
☐ Multiple semester waivers will be given for the current academic year only and only if the coverage dates of your policy include the dates of the semesters for which you are making application.
☐ Waiver applications will only be accepted during the scheduled waiver period dates.

Revised 04/25/2011
Part 3:

I certify that my current health insurance coverage meets or exceeds the minimum coverage that was listed on the previous page. I understand that I will be assessed a $25 per semester fee to pay for the required medical evacuation/repatriation coverage, unless I attach proof of medical evacuation benefits of at least $10,000 and repatriation benefits of at least $7,500. I understand that the sole purpose of UTD’s review of this waiver is to determine if I qualify for a waiver of enrollment in the Student Health Insurance Plan. I certify that my health insurance coverage is in effect and will remain in effect for the entire UTD Student Health Insurance coverage period for the semester I am requesting this waiver. UTD’s review of this application does not constitute a determination by UTD as to the adequacy of this coverage for any purpose. I understand that I am legally responsible for my own medical expenses and that UTD is not responsible for such expenses.

Student Signature ___________________________________________ Date __________________________

SHC Approval Signature ___________________________________________ Date __________________________

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OFFICE USE ONLY

<table>
<thead>
<tr>
<th>Semesters Waived</th>
<th>Repatriation / Evacuation Codes</th>
<th>Reason For Denied Waiver:</th>
</tr>
</thead>
<tbody>
<tr>
<td>2132</td>
<td>EV1    EV2</td>
<td>__________________________</td>
</tr>
<tr>
<td>2135</td>
<td>EV1    EV2</td>
<td>__________________________</td>
</tr>
</tbody>
</table>