



The University of Michigan-Dearborn
Office of International Affairs
4901 Evergreen Rd
2106 RUC
Dearborn, MI 48128
Tel: 313-583-6600
Email: umdoia-international@umich.edu

International Health Insurance Waiver Request Form

- **Students Participating in Curricular Practical Training (CPT) are not eligible to waive their University of Michigan- Dearborn Student Health Insurance Plan.**

This form is used to request a waiver of the mandatory insurance requirement for F1 and J1 students or scholars whose Forms I-20 or DS-2019 were issued by UM-D. Do not use this form if you are a J1 Scholar with UM-Benefits (use the J1 Scholar Waiver Form on OIA's website instead). The purpose of this form is to gather information about your private or sponsor-provided health insurance so that we can determine whether or not it meets University of Michigan standards for international health insurance. If it does, we will approve your insurance waiver request and cancel your enrollment in the International Student/Scholar Insurance Plan (BCN). **This form must be submitted to the Office of International Affairs (OIA) before the following term's deadline date: Fall - October 1st, Winter - February 1st or Summer - June 1st** (for scholars the deadline is within 30 days of arrival). Note: if you are an Exchange Student it is recommended that you submit this form 30 days prior to your arrival.

Instructions:

- 1) Fill out section 1 and ask your insurance company representative to fill out section 2, or to attach a letter to this waiver request form confirming that your insurance policy meets **all** UM standards listed here on pages 2 & 3.
- 2) Fill out the *International Health Insurance Waiver Request Form* (this form) and attach:
 - Proof of enrollment in the insurance plan, such as a copy of your insurance card or your certificate of insurance or a letter from your insurance company stating that you are covered by the plan. If your insurance plan covers your dependents, please also attach proof that they are covered by the plan.
- 3) Return this form and all supporting documentation to the Office of International Affairs (OIA) in person or via email at umdoia-international@umich.edu. You will be notified via email if your waiver request is approved or denied within 14 days provided that the forms and attachments contain enough information to evaluate your waiver request.

Section 1 (to be completed by student or scholar):

Name: _____
Last First

UMID: _____ Birth date: _____ (mm/dd/yyyy) Gender: M F

Email address: _____

Names and Dates of Birth of Insured Dependents:

Name of Insurance Company: _____ Policy Number: _____
Visa Type: _____ Status: Graduate Student Undergraduate Student Visiting Scholar

*Requested Waiver Dates: From: _____ To: August 31st or _____

***Note: all waivers expire on August 31, and must be renewed each September**

Type of coverage: Self Self + Spouse Self + 1 child Self +2 or more in family

If your coverage is provided by a family member:

Name: _____ Birth date (mm/dd/yyyy): _____

Relationship to Insured: _____

Before you send this form to your insurance company, please sign and date here to give your insurance company permission to verify your insurance.

Your Name: _____
 Last First

Your Signature: _____ Date: _____

Your Insurance Company: _____ Your Policy Number: _____

Section 2 (To be completed by an insurance company representative):

TO THE INSURANCE COMPANY: Your customer – who has signed the release, above, permitting you to share this information – requests that you indicate whether or not the insurance policy named above meets the following University of Michigan-Dearborn requirements. **Coverage for all requirements must be available in the U.S.** We will accept a separate letter which states the policy meets all of these standards. The letter must be attached to this information sheet.

Information about Coverage	
Is there a U.S. phone number for the insurance claims agent? <i>Insurance plans where you pay the health care provider then the insurance company reimburses you are not acceptable.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/> Please list phone number here: _____
Is this plan in full compliance with applicable federal law (specifically Title IX of Education Amendments of 1972, as amended by the Civil Rights Restoration Act of 1987)? Specific components of these laws include pregnancy treated as any other medical condition. <i>Insurance plans that exclude maternity coverage or severely limit it will not be accepted. Maternity coverage must be similar to coverage for other medical conditions.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
This Section: Any “yes” answers indicate that the coverage is <i>not</i> comparable to the UM International Student/Scholar Insurance Plan and therefore is <i>not</i> acceptable.	Does this insurance cover “ emergencies only ”? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Does this insurance pay for a patient’s condition to be “ stabilized ” but then require the patient to be returned to the home country for treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is this Travel Insurance? <i>Travel insurance is insurance that is in effect for a short period time (60 – 90 days, for example) and is designed for short trips. Insurance that you plan to substitute for the UM International Student/Scholar Health Insurance Plan should be in effect at least through August 31 of the current academic year unless you plan to leave the University permanently before then.</i> Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is this coverage MediShare or another form of a cost-sharing arrangement that is not true medical insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>

➔ **The Insurance Information Coverage continues on the following page**

➔ **Continued from previous page**

<p>Is this insurance plan compliance with the Affordable Care Act? <i>This means, for example, that your plan:</i></p> <ul style="list-style-type: none"> • <i>Cannot have an annual or lifetime limit on benefits.</i> • <i>Must have 100% coverage for preventive care.</i> • <i>Cannot exclude or limit coverage for pre-existing conditions.</i> 	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover at least 80% of usual and customary charges in the Dearborn, Michigan area for hospital room, board, miscellaneous hospital expenses, physician expenses in and out of the hospital, ambulance service, outpatient labs, x-rays, and diagnostic tests? <i>The plan may not contain specific limitations for the treatment of medical conditions relative to standard hospital or outpatient care. For example, an insurance plan that limited coverage of hospital room and board to \$500 or limited coverage of ambulance costs to \$350 would not be acceptable.</i></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does the insurance plan have a deductible of no more than \$100 per policy year, or \$200 per policy for families?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover at least 90% of usual and customary charges for prescription drugs?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover both inpatient and outpatient mental health treatment and cover treatment for substance abuse (both alcohol and drug abuse)? <i>A specific level of coverage for mental health treatment is not required. However, coverage for mental health treatment should not be significantly lower than the coverage provided by the UM International Student/Scholar Insurance Plan. The UM International Student/Scholar Insurance Plan covers inpatient mental health treatment with a co-pay of \$150 per admission (in network) or 20% coinsurance (not in network). Outpatient mental health services are covered with a co-pay of \$20 per visit (in network) or 20% coinsurance (not in network).</i></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Does this insurance plan cover treatment for self-inflicted injuries and services related to suicide?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Are there <i>any</i> differences between coverage for the primary insured and dependents? If yes, please specify: _____</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

Insurance Company Certification	
I hereby certify that all information on this form is complete and accurate, and that health insurance for the student or visiting scholar and covered dependents (if any) listed above meets all requirements set forth above.	
Insurance Company Representative Name:	_____
Signature: _____	Date: _____
Position or Title:	_____
Company Name:	_____
Telephone Number: _____	Fax Number: _____
Email address:	_____

Form last updated 6/2024