

SIDE ONE (FRONT)

**INTERNATIONAL STUDENT HEALTH INSURANCE
WAIVER REQUEST APPLICATION FORM**

(This is a request to have the Student Health Insurance Fee removed from the Bursar Account of those students who have alternate insurance coverage that meets all the criteria shown on the back of this form)

Students applying for a waiver must complete the entire waiver form, attach all information requested and return it to a waiver collection location before the deadline listed below for EACH semester. No application for a waiver will be accepted after the deadline shown below for each Fall, Spring/Summer (or Summer Semesters for newly enrolled students).

- Upon returning your waiver application you will sign a numbered "Daily Log Sheet". The number corresponding to your name will be written on your waiver form. No student will be given on the spot "yes" or "no" responses when returning student insurance waiver applications to the collection site.
- Waivers will be batched by number and reviewed.
- "Accepted/Approved" Waivers will be credited to each student's account to remove the insurance charge.
- An email response from macori@macori.com will be sent to each student indicating whether the waiver application was "accepted" or "denied". If denied, the e-mail will reflect the reason for denial. In approximately 10 business days you may check your waiver status on-line at: www.macori.com/OU
- Be certain copies of all information are attached, or the waiver could be denied. Neither OU nor Macori accepts the responsibility for contacting your insurance provider in order to obtain information on your behalf.

You will need to repeat this process **EACH SEMESTER** for which a waiver is desired.

THIS APPLICATION FORM MUST BE COMPLETED. PLEASE PRINT LEGIBLY SO PROPER CREDIT IS RECEIVED:

_____	_____	_____	____/____/____
Last Name	First Name	Student ID #	Date of Birth
_____	_____	_____	_____
Street Address	Apt. #	Daytime Telephone #	
_____	_____	_____	
City	Zip Code	Campus Email Address (REQUIRED)	
Is this a new address?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
			Country of Citizenship

Deadline for presenting waiver applications is shown below.

	<u>Waiver Deadline</u>
<input type="checkbox"/> Summer Semester	June 16, 2011

Note: As part of the acceptance criteria to OU, you agreed to purchase and maintain Health Insurance which meets or exceeds criteria established by OU (as shown on Side 2 of this form) for the duration of your enrollment. Non-immigrant International Students/ Scholars on an F or J visa enrolled in credit courses will be automatically billed for Student Health Plan II for each Semester he/she is enrolled, unless proof of other adequate acceptable insurance is presented and approved EACH SEMESTER, prior to waiver deadlines (See "International Student Waiver Application Information" under Helpful Links at www.macori.com/OU). If you withdraw from OU prior to the 31st day of the semester, your coverage will become null and void (See Plan Document for medical withdrawal exception).

FOR OFFICE USE ONLY

_____	_____
Student Health Plan Official Signature	Date Waiver Completed
A. Waiver # _____	Approved <input type="checkbox"/> Yes <input type="checkbox"/> No
	Add Medical Evacuation/Repatriation <input type="checkbox"/> Yes <input type="checkbox"/> No
B. Semester, Year _____	

SIDE TWO (BACK) – You must complete the following in order to apply for a waiver of the OU Student Health Plan Fee.

I am insured for the ENTIRE SEMESTER under the policy I have indicated below which meets or exceeds OU's insurance waiver criteria. (Check either Selection #1 or Selection #2 and attach to this waiver form a copy of each item listed under your selection).

MAKE A SELECTION:

Selection #1

I Am Insured Through My Work (or insured as a dependent through my parent(s) or spouse's job based employer's health insurance plan). DO NOT complete a waiver if you are a benefit eligible Student Graduate to be covered under the OU Student Health Plan:

Attach a letter of verification from the Employer, which states the dates of your coverage (must be eligible for the entire semester), coverage limit and whom to contact for employee benefit insurance verification. The letter must be on Company letterhead stationery. This plan must be equal to or exceed the Policy Criteria Checklist on the right.

A. Complete the following

1. Employer Company (Department) Name: _____
2. Employer (Department) Telephone Number: _____
3. U.S. Telephone Number: _____

B. If the policy does not contain at least \$10,000 for Medical Evacuation and \$7,500 for Repatriation of Remains, you will be charged a nominal fee on your bill for this coverage.

Selection #2

I Am Insured Through a Private Policy (backed by my Government/Embassy):

A. Attach a copy of the Policy (must be in English and amounts shown in U.S. Currency). This plan must be equal to or exceed the Policy Criteria Checklist on the right.

1. Insurance Company Name: _____
2. U.S. Telephone Number: _____
3. Country of Citizenship: _____

B. Attach a copy of Proof of Purchase and Coverage Dates (can be valid ID card if there is a U.S. telephone number on the ID card, but policy must be attached as stated in "A" above). The Student must be covered under this policy for the entire semester/period for which he/she is applying to waive.

C. If the policy does not contain at least \$10,000 for Medical Evacuation and \$7,500 for Repatriation of Remains, you will be charged a nominal fee on your bill for this coverage.

Policy Criteria Checklist:

- a. Medical benefits of at least U.S. \$50,000 for each accident or sickness
- b. Annual deductible of no more than U.S. \$500
- c. Covered benefits paid at a minimum of 75%
- d. *Repatriation of Remains U.S. \$7,500 minimum
- e. *Medical evacuation U.S. \$10,000 minimum
- f. Policies may not exclude or unreasonably limit coverage for activities essential for students.

* A nominal charge will be added for these benefits if they are not included in an otherwise acceptable policy.

Student Affidavit: I present the above information as being true and accurate. I understand that a waiver will not be granted if any of the following occur: (1) Information forms or attachments are incomplete or inaccurate; (2) Insurance does not meet OU's insurance waiver criteria; (3) Information is presented to the OU Student Health Plan Office **after the waiver deadline**.

I am fully aware that neither the University of Oklahoma nor their agents or servicing entities are responsible for interpretation or review of the policy information presented to obtain this waiver, or any expenses resulting therefrom. I agree to be responsible for advising the OU Student Health Plan Office (in writing) of any lapses or cancellations of my current policy during the semester for which I enrolled.

Student Signature

Date Signed

**** Incorrect or false information could affect your Visa status. Please make certain you are never without appropriate insurance coverage. ****