Academic Year 2014-2015 Waiver Form — Fort Hays State University

Kansas Board of Regents policy states "Each state university shall require any international student holding a F-1 visa and any exchange visitor holding a J-1 visa to show proof of health insurance coverage for each semester or term for which the student is enrolled, whether or not the student is participating in the Board's voluntary student health insurance program. Such proof of insurance shall be required prior to the student beginning classes."

All international students are *automatically* enrolled in the KBOR Student Health Insurance Plan. If you wish to waive out of this coverage, *you must complete and return this waiver form along with proof of adequate health insurance coverage from another health plan that meets the university's* requirements. New waiver requests must be submitted EVERY fall or, if other coverage is for less than academic year, a new waiver request must be submitted for each semester or summer for which the student is enrolled.

Directions:

Complete Sections A & B of this form and bring or fax the completed form along with proof of your other health insurance (including your ID card) to the Student Health Insurance Coordinator **BEFORE** the applicable waiver deadline(s) listed in Section A. **Waivers received after the deadline will not be approved.** Waiver **Deadline**: *Monday*, *August 18*, *2014—Fall semester & Tuesday*, *January 20*, *2015--Spring semester*

Please Print_						
following duration. (Please chose one option)			8/18/2014-12 ☐ Spring Ser	□ Fall Semester 8/18/2014-12/31/2014 □ Spring Semester 1/1/2015-5/31/2015 □ Summer Semester 6/1/2015-7/31/2015		
Student Information						
Last Name/Family Name First Name/Given Name			fiddle Initial University Student I.D. #			
Local Address	City	State	ZIP	Birth Date (Month/Day/Year)	□ Female	
Telephone	Fax	Email		/ /		
()	()					
		and coverage:	responsible for	any of my medical exp	oenses.	
B. Coverage for essential benefits as d and Affordable Care Act – includin maternity, preventive care, contrace C. A pre-existing conditions exclusion reasonable (9 months or less) D. A policy year deductible of \$500 or pocket expense (deductible plus out exceed \$10,000 E. A minimum of \$10,000 for repatrice vacuation.	ximums) efined under Patient Protection g pharmacy, mental health, eption — with no dollar limits waiting period that is eless. Maximum total out of e-of-pocket maximum) cannot J.	network prov waiver Verifiable pro policy or lette Effective date waiver Attach copy of covers) in En Insurer has a	iders. Emergency/toof of coverage with the from insurance case covering the entitle of insurance policy glish, with currence	e payable by the insurance argent care only is not accell the student's name (ID card, arrier – copy provided) re period for which I am re (explanation of what your y amounts converted to U. in the US or have a US bast phone number.	insurance equesting a insurance S. dollars.	
Name of Insurance Company			Insurance Com	pany Telephone Contact in US		
			()			
Name of Employer (if applicable) N/A				Insurance Policy #		
Insured Name			Relationship to Student			
Signature			Date			
For Office Use Only — Do No	ot Write Below Line					
·				Attention Students: You must hand-deliver or scan and email this form,		
Form Received By Coverage Verified to Meet Criteria in Section B:	Date (Insurance Coordinator)	with your proof of other adequate health insurance coverage, to the Student Health Insurance Coordinator on your campus.				
Copy of ID Card/ Policy Received:	(Insurance Coordinator)		☐ Hand deli	ver to campus-FHSU She kohl@fhsu.edu	ridan Hall 208	
Waiver Accepted	Waiver Denied			Keep a copy of your fax log as proof of fax transmittal		