UNIVERSITY of NORTH TEXAS

UNT STUDENT HEALTH INSURANCE WAIVER REQUEST FORM—FALL 2009

PRINT IN BLOCK LETTERS: Write clearly.

NAME: _____
Family/Last name Given name Middle Name

DATE: _____

Status ( ) IELI ( )Bachelor ( ) 2nd Bachelor ( ) Masters ( ) Doctorate ( ) Other _____

UNT ID# [___|___|___|___|___|___|___|___| **PHONE: ( )** _____

Current Visa type: F-1( ) J-1( ) H-1( ) Other- specify type_____

UNT Eaglemail address = EUID: _____**@unt.edu**

TYPE 1

( ) Government-sponsored medical insurance from your home country with equal or greater coverage than listed below. Take documentation to Sponsored & Special Programs, Kendal Hall, Room 231.

TYPE 2

( ) Coverage provided by a U.S. employer with equal to or greater coverage than listed below.

****FILL IN THE BLANKS BELOW WITH INFORMATION ABOUT YOUR INSURANCE****

PROOF: Attach copy of insurance benefits with your name or a letter from the employer if your name is not on the card.

Name of the Insurance company: _____

Name of the employed person who has the medical insurance: _____

Your relationship to that person: _____

Name of the company for whom the person works: _____

TYPE 3

( ) UNT EMPLOYEE INSURANCE: NAME OF EMPLOYING DEPT. _____

PROOF: Attach the Human Resources form (NOT the Employment Waiver from your department).

( ) Coverage begins the first day of the semester with NO 90-day waiting period.

( ) Coverage begins the first day of the month following a 90-day waiting period
Student must show proof of insurance for the waiting period (usually 4 months). If no insurance is shown, the UNT medical insurance will be automatically charged.

****FILL IN THE BLANKS BELOW WITH INFORMATION ABOUT YOUR INSURANCE:****

Beginning date: _____ (08/15/09 or earlier) Ending date: _____ (01/08/10 or later)

Amount of coverage per accident/illness in US $: _____ ($100,000 per injury/illness)
Amount of medical evacuation coverage in US $: _____ ($10,000 required)
Amount of repatriation coverage in US $: _____ ($7,500 required)
Amount of deductible in US $: _____ ($500 maximum)
Policy written in English ( ) YES Pays for U.S. medical treatment ( ) YES

HIGHLIGHT the above pieces of information on your insurance documentation and proof of payment. Attach documents to this form.

I understand that by waiving out of the UNT sponsored insurance plan, I am responsible for paying all charges incurred at the SHWC at the time of service and for filing my own insurance claims.

_____ _____
Signature of student requesting waiver Date

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OFFICE USE ONLY: Date received: _____

Waiver date(s)

NOTES:_____

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