

**INTERNATIONAL HEALTH INSURANCE WAIVER PETITION**

**Deadlines:**

**Entering Term: Fall 2008—Monday, September 15, 2008**

**Entering Term: Spring 2009—Monday, January 19, 2009**

Loyola University requires that all F-1 and J-1 students have health insurance. You will be charged an insurance fee and covered under a policy obtained by Loyola on your behalf, unless you submit proof of comparable personal coverage. A representative of your insurance company must complete this waiver form, you must submit a copy of your insurance card, and your coverage must include all of the following benefits in order to be accepted by Loyola University. If it does not meet these requirements, then you must purchase the policy made available by the university. Please note the deadlines above for receipt of waiver petitions by the Center for International Education office.

**TO BE COMPLETED BY STUDENT**

I request and authorize my insurance company to answer the following statements regarding my health insurance coverage.

Date: \_\_\_\_\_ Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(MM/DD/YYYY)

Policy Number: \_\_\_\_\_ Student's Signature: \_\_\_\_\_

I understand that granting this waiver is at the sole and final discretion of Loyola University New Orleans. If the waiver is granted, I release Loyola University New Orleans from any liability for any issue of medical coverage.

**TO BE COMPLETED BY HEALTH INSURANCE REPRESENTATIVE**

The above named student has requested that you complete this form regarding his / her health insurance coverage with your company. This form can be faxed to (504) 864-7548 or completed on company letterhead and mailed to Loyola University New Orleans, 6363 St. Charles Avenue, Box 205, New Orleans, LA 70118.

**Please answer YES or NO to the following statements:**

- \_\_\_\_\_ This plan includes repatriation benefits of at least \$10,000. If NOT, then how much? \_\_\_\_\_
- \_\_\_\_\_ This plan includes medical evacuation coverage of at least \$25,000. If NOT, then how much? \_\_\_\_\_
- \_\_\_\_\_ This plan will provide medical benefits to policyholders residing in Louisiana.
- \_\_\_\_\_ This plan has a U.S. telephone number for claims inquiries. If yes, the phone number is \_\_\_\_\_.
- \_\_\_\_\_ This plan is a major medical health plan covering the policyholder in or out of the hospital.
- \_\_\_\_\_ This plan provides at least \$250,000 reimbursement per illness or accident for each insured person.
- \_\_\_\_\_ This plan has a deductible that does not exceed \$500.00 per accident/illness. If NOT, then how much is the deductible? \_\_\_\_\_
- \_\_\_\_\_ This plan is currently in effect and will remain in force until August 14, 2009 (or beyond). If NOT, then when does the plan end? \_\_\_\_\_

Please attach a copy of the Declarations Page, listing the benefits, from the student's current Insurance Policy.

\_\_\_\_\_  
Name and Title of Insurance Representative Signature

\_\_\_\_\_  
Health Insurance Company Telephone Number Fax Number

Office Use Only: Rec'd \_\_\_\_\_ Action: \_\_\_\_\_ By: \_\_\_\_\_