LOYOLA UNIVERSITY NEW ORLEANS

CENTER FOR INTERNATIONAL EDUCATION

INTERNATIONAL HEALTH INSURANCE WAIVER PETITION

Deadline: Entering Term: Fall 2018—Wednesday, August 1, 2018
Deadline: Entering Term: Spring 2019—Monday, December 10, 2018

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 BEFORE the date listed above. A representative of your insurance company must complete this waiver form and your coverage must include all of the benefits listed below 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.

TO BE COMPLETED BY STUDENT

Date: _____ Student's Name: _____ Date of Birth: _____

I will enroll in the insurance policy provided by Loyola: YES _____ NO _____

If NO, I request and authorize my insurance company to answer the statements below.

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 scanned and emailed to cie@loyno.edu.

Please answer YES or NO to the following statements:

_____This plan includes repatriation benefits of at least $25,000. If NOT, then how much? _____
_____This plan includes medical evacuation coverage of at least $50,000. 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 15, 2019 (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: _____