

**Pacific Lutheran University
International Student Insurance Plan Waiver
2009-2010**

Pacific Lutheran University (PLU) requires all international students to maintain medical insurance that provides coverage in the United States and meets certain minimum benefit requirements. To ensure this, PLU will automatically enroll all international students in PLU's International Student Accident and Sickness Plan (Student Insurance Plan). The insurance premium will automatically be added to your university bill at the time of registration. If students wish to have PLU's International Student Insurance Plan waived, they must provide proof that their alternate policy provides benefits at least equal to those required by Pacific Lutheran University. This compliance form must be used to provide this information to the university.

Instructions to Student: Ask your insurance company representative to complete this form and return it to Pacific Lutheran University. If your representative has any questions regarding this form, please call Sue Liden, Manager, Finance and Operations at (253) 535-7121.

Release Information: I hereby permit my insurance company to release the following information to staff persons at Pacific Lutheran University. Also, I understand the International insurance requirements established by Pacific Lutheran University and agree to abide by them. I understand that if the waiver is approved, it is only for school year 2009-2010. I further understand that I must apply for a waiver each year.

I understand that if my alternate insurance is not approved, this does not mean that Pacific Lutheran University, or any of its employees, recommend that I cancel my existing, pending or proposed insurance coverage. A denial implies only that the policy presented does not meet the minimum criteria established by the university with respect to specific medical insurance coverage criteria required for registration and/or enrollment.

Student Name _____ PLU ID number _____

Student Signature _____ Date _____

Instructions to Insurance Company: Please complete this form and mail to: **Health Center, Pacific Lutheran University, Tacoma, WA 98447** or fax to (253) 536-5042. Indicate the insured's name, the insurance company name, U.S. claims agent/address/phone, policy number and dates of commencement and termination of coverage.

Student Name (Last/Family) _____ (First) _____

Insurance Company Name _____ Policy Number _____

Date Coverage Begins: _____ Date Coverage Ends _____

U.S. Claims Agent Address: _____

U.S. Claims Agent Phone Number: _____

The insurance policy must include the following basic benefits. Please state YES or NO for each item listed.

- _____ 1. Coverage period: 52 continuous weeks.
- _____ 2. Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, laboratory and diagnostic procedures for outpatient expenses paid at 80% of usual customary, reasonable (UCR) fees in U.S. currency.
- _____ 3. Mental health care to a maximum of \$500 per illness for outpatient services
- _____ 4. Inpatient/Outpatient prescription medication coverage to a limit of \$500 per year.
- _____ 5. Repatriation: \$7500 (coverage to return remains to the home country)
- _____ 6. Medical evacuation: \$10,000 (to permit patient to be accompanied by an escort if directed by the Physician in charge.)
- _____ 7. Deductible \$100 or less
- _____ 8. Aggregate Cap: \$50,000 for covered injuries/illnesses per individual Student
- _____ 9. Claims Agent located in the United States.

I, _____ a(n) _____ for _____ have verified
(Representative's Name) (Position) (Insurance Company Name)

the information on this form and completed each item above. The insurance company listed above will pay their claims in U.S. funds. If the above noted policy is terminated, the insurance company will notify Pacific Lutheran University immediately. As a representative for the insurance company I certify that the coverage indicated is now in force.

Signature: _____ Date: _____

Telephone Number: _____ Fax Number: _____

**Deadline for receipt of this form is September 21, 2009. There will be no exceptions.
Form must be received by the Health Center, Pacific Lutheran University, Tacoma, WA 98447; fax (253)536-5042**