

**Pacific Lutheran University  
International Student Insurance Plan Waiver  
2018-2019**

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. Students who have insurance provided by their government are eligible to waive this insurance. You must provide proof that the benefits provided by your government policy are 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, Director, Risk Management & Insurance 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 academic year 2018-2019.

I understand that if my 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: **Pacific Lutheran University, Attn: Administrative Services, Tacoma, WA 98447** or fax to (253) 536-5047 or email to [fadmin@plu.edu](mailto:fadmin@plu.edu). Indicate the insured's name, the insurance company name, U.S. claims agent/ U.S. address/U.S. 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 U.S. Address \_\_\_\_\_

U.S. Claims Agent U.S. 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. (If student is enrolled for only one semester, coverage must be in place for that period.)
- \_\_\_\_\_ 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 paid as any other sickness, 80% of UCR
- \_\_\_\_\_ 4. Unlimited Inpatient/Outpatient prescription medication coverage, co-pay is acceptable.
- \_\_\_\_\_ 5. Repatriation: \$50,000 (coverage to return remains to the home country)
- \_\_\_\_\_ 6. Medical evacuation: \$25,000 (to permit patient to be accompanied by an escort if directed by the Physician in charge.)
- \_\_\_\_\_ 7. Deductible \$100 or less
- \_\_\_\_\_ 8. No Aggregate Cap
- \_\_\_\_\_ 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 4, 2018. There will be no exceptions.**  
Pacific Lutheran University, Office of Administrative Services, Tacoma, WA 98447  
Fax (253) 536-5047 or email [fadmin@plu.edu](mailto:fadmin@plu.edu)