Western Oregon UNIVERSITY

International Insurance Waiver Information Sheet

This Document Must Be Read and Completed Before Completing Your Waiver Form and for Final Acceptance of Submitted Waiver

WAIVER REQUIREMENTS

1. I understand that a waiver form must be submitted each academic term that I am an international student at Western Oregon University.
   ☐ Yes, I understand I must waive each academic term.

2. I understand that if I am an International Student, I may not waive the Gallagher Student Health Insurance Plan unless I am covered by an insurance plan based in the United States* that is comparable to the plan offered by Western Oregon University. ***Plans based in a US Territory (Guam, Virgin Islands, Puerto Rico) are not comparable and cannot be used to waive the school's Student Medical Insurance Plan.***
   ☐ Yes, I am an International Student and understand the requirements above.

BENEFITS REQUIREMENTS

Frequently, students arrive on campus enrolled in a health insurance plan that does not provide adequate coverage while attending school. Please check with your current health insurance plan regarding the following before waiving coverage.

1. My current Health Insurance Plan provides coverage for the entire term I am requesting to waive as an eligible student.
   ☐ Yes, my current plan meets these requirements
   ☐ No, my current plan does not meet these requirements

2. My current Health Insurance Plan provides Medical Benefits of $100,000 per condition
   ☐ Yes, my current plan meets these requirements
   ☐ No, my current plan does not meet these requirements

3. My current Health Insurance Plan provides Repatriation of Remains of at least $25,000
   ☐ Yes, my current plan meets these requirements
   ☐ No, my current plan does not meet these requirements

4. My current Health Insurance Plan provides Medical Evacuation to my home country in the amount of $50,000
   ☐ Yes, my current plan meets these requirements
   ☐ No, my current plan does not meet these requirements

5. My current Health Insurance Plan provides a Deductible to not exceed $500 per condition
   - ☐ Yes, my current plan meets these requirements
   - ☐ No, my current plan does not meet these requirements

6. My current Health Insurance Plan provides Pre-Existing Condition waiting period for conditions which are determined by current industry standards
   - ☐ Yes, my current plan meets these requirements
   - ☐ No, my current plan does not meet these requirements

7. My current Health Insurance Plan provides Coverage Available in the United States and has a Physical U.S. Based Office
   - ☐ Yes, my current plan meets these requirements
   - ☐ No, my current plan does not meet these requirements

8. My current Health Insurance Plan provides coverage for inpatient and outpatient hospitalization in the Monmouth, OR area.
   - ☐ Yes, my current plan meets these requirements.
   - ☐ No, my current plan does not meet these requirements.

9. My current Health Insurance Plan provides access to local doctors, specialists, hospitals and other health care providers in emergency and non-emergency situations in the Monmouth, OR area.
   - ☐ Yes, my current plan meets these requirements.
   - ☐ No, my current plan does not meet these requirements.

10. My current Health Insurance Plan provides coverage for lab work, diagnostic xrays, physical therapy and chiropractic care, emergency room treatment, ambulance services, and prescription coverage in the Monmouth, OR area.
    - ☐ Yes, my current plan meets these requirements.
    - ☐ No, my current plan does not meet these requirements.

11. My current Health Insurance Plan provides coverage for inpatient and outpatient mental health, substance abuse and counseling services in the Monmouth, OR area.
    - ☐ Yes, my current plan meets these requirements.
    - ☐ No, my current plan does not meet these requirements.

If you have answered no to any of the questions **STOP**, you are not qualified for a Waiver from the WOU International Insurance policy.

If you have answered **yes to all** of the questions above, please continue to the next page.

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International Insurance Waiver Form

Western Oregon University requires that all international students registered at WOU need to be enrolled in a health insurance plan while attending the university. Students are not required to enroll in the Gallagher Student Health Insurance Plan made available through Western Oregon University if they can document proof of other comparable coverage by completing this Waiver Form and submitting proof of coverage from a U.S. based company.

Students who do not complete this Waiver Form by the deadline will be automatically enrolled in and billed for the WOU/Gallagher Student Health & Special Risk Plan.

This is a per term process and you will be required to submit a Waiver Form at the beginning of each academic term by the deadline. **Deadline to submit a waiver is:** January 12th, 2024.

If you have any questions on this process, please email at global@wou.edu.

Student Information

First Name _____ Last Name _____

Student ID _____ Date of Birth (mm/dd/yyyy) _____ Gender _____

Local Address _____City _____ State _____ Zip _____

Phone Number _____ WOU Email _____

Waiver Information

If you want to **waive** the Gallagher Student Health Insurance Plan, please check the appropriate box below and complete the following section Insurance Company Information.

I want to WAIVE participation in the Gallagher Student Health Insurance Plan for

- ☐ Winter 2024
- ☐ Spring 2024
- ☐ Summer 2024
- ☐ Fall 2024
- ☐

I understand by waiving coverage, I am waiving coverage for the term selected above and will not be able to enroll at a later date unless I lose coverage under my current health insurance plan.

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*Please complete the 'Insurance Company Information' section and provide **a copy of your policy** along with this form. Your waiver will not be accepted without proof of coverage from the Insurance Company listed below.*

Insurance Company Information

Name of Insurance Company _____

Is Company based in the U.S.? ☐ Yes ☐ No

Insurance Company Street Address/PO Box _____

Insurance Company City _____ State _____ Zip Code _____

Phone Number (800# Preferred) _____

Name of Policy Holder _____

Policy Holder ID# _____

Type of Insurance _____ Subscriber/Member ID# _____

I acknowledge that by waiving the Gallagher Student Health Insurance Plan, I confirm that I am currently enrolled in a health insurance plan and will be continuously insured for the school year, that I have reviewed both plans and have determined my current coverage to be comparable. I further acknowledge that by waiving the Gallagher Student Health Insurance Plan, I will be solely responsible for any medical expenses I may incur and that neither Western Oregon University nor Gallagher Student Health & Special Risk will be held responsible for any medical expense.

I further understand that by submitting this form, I am granting permission for Gallagher/Western Oregon University to audit this information for documentation purposes. If the information provided on this form is falsified, I understand that I will be enrolled in the Gallagher Student Health Insurance Plan and will be charged the full insurance premium.

Student Signature _____ Date _____

FOR OFFICE USE ONLY

YOUR PETITION WAS: APPROVED DENIED OTHER BY:_____ DATE: _____

- ❑ Banner: Charges Removed
- ❑ Banner: Charges Added
- ❑ Individual Insurance Policy Submitted

REMARKS: