Western Oregon UNIVERSITY

# International Health 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 (whether enrolled or not enrolled in classes).

Students may waive enrollment in the Gallagher Health Insurance Plan made available through Western Oregon University if they can provide proof of a comparable coverage from a U.S. based company and complete the Waiver Form.

This is a per term process and you will be required to submit a Waiver Form at the beginning of each academic term.

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

## Student Information

First Name _____ Last Name _____

Student V# _____ WOU Email _____

Local Address _____ City _____ State _____ Zip _____

Phone Number _____

## Waiver Information

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

- ☐ Fall 20____
- ☐ Winter 20____
- ☐ Spring 20____
- ☐ Summer 20____

☐ 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.

☐ I understand that I may not waive the Gallagher 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) <u>are not</u> comparable and cannot be used to waive WOUs Health Insurance Plan**.

☐ I will provide proof of my health insurance plan which will include the coverage dates.

Western Oregon UNIVERSITY

# Benefit Requirements

Frequently, students arrive on campus enrolled in a health insurance plan that does not provide adequate coverage while attending school. Before waiving the Gallagher Health Insurance Plan, please ensure your health plan coverage meets the requirements listed below:

**My current Health Insurance Plan provides:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Coverage for the entire term I am requesting to waive as an eligible student. |
| ☐ | ☐ | Medical benefits of $100,000 per condition |
| ☐ | ☐ | Repatriation of remains of at least $25,000 |
| ☐ | ☐ | Medical evacuation to my home country in the amount of $50,000 |
| ☐ | ☐ | A deductible to not exceed $500 per condition |
| ☐ | ☐ | A pre-existing condition waiting period for conditions which are determined by current industry standards. |
| ☐ | ☐ | Coverage available in the United States and has a physical U.S. based office. |
| ☐ | ☐ | Coverage for inpatient and outpatient hospitalization in the Monmouth, OR area. |
| ☐ | ☐ | Access to local doctors, specialists, hospitals and other health care providers in emergency and non-emergency situations in the Monmouth, OR area. |
| ☐ | ☐ | Coverage for lab work, diagnostic x-rays, physical therapy and chiropractic care, emergency room treatment, ambulance services, and prescription coverage in the Monmouth, OR area. |
| ☐ | ☐ | Coverage for inpatient and outpatient mental health, substance abuse and counseling services in the Monmouth, OR area. |

If you have answered **NO** to any of the questions **STOP**, you are not qualified for a Waiver from the WOU International Insurance policy because your plan is not comparable.

If you have answered **YES** to all the questions above, you are eligible to waive enrollment in Gallagher Student Health Insurance plan.

Western Oregon UNIVERSITY

# 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 Health Insurance Plan, I confirm that I am currently enrolled in a health insurance plan and will be continuously insured for the school year, and I have reviewed both plans and have determined my current coverage to be comparable. I further acknowledge that by waiving the Gallagher 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 Health Insurance Plan/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 _____