University of Idaho
International Programs

International *Dependent (spouse and/or children)* Health Insurance Compliance Form

Forms Due: Before Classes Begin

Insured's Name: _____
(Family or Last name) **(Given or First name)**

Visa Status for Insured (check one): *J-2◯** *F-2**◯** *Fill in spouses student UI information below**

UI Student ID#: _____ **UI Email Address:** _____

Instructions to the Student/Dependent:
International students and dependents holding non-immigrant visas must purchase health insurance.

Option A: Purchase University of Idaho Student Health Insurance Program (SHIP).

- You are automatically charged for SHIP when you register for classes. You will see SHIP on your bill from the UI for each semester. You do not have to fill out this form.
- If you have dependents they will also be automatically charged the SHIP.
- Find out the cost of SHIP and what is covered at: http://www.health.uidaho.edu/ship

Option B: Purchase a medical insurance that meets or exceeds the U.S Department of State Requirements.

- If you choose not to purchase SHIP you are required to complete this form. Sign the first page of this form and send *both* pages to your medical insurance provider/company. The medical insurance company will complete and sign the second page of this form. Your student account will be charged for SHIP if the waiver is not received before classes begin.

***Please Note**:* You and your dependents are required to have health insurance the day you enter the U.S. (SHIP covers up to 15 days before classes begin). Complete proof of coverage is required before a waiver can be processed. If any of the benefits listed on the second page are not covered under the medical insurance you have provided, your insurance is considered inadequate and you will continue to be billed for SHIP when you register for classes.

The following applies to all students/dependents that have non-immigrant visas:

- I understand this application must comply with appropriate UI standards or I may be subjected to penalties affecting my enrollment in the university.
- I understand that if my insurance coverage (for which my waiver approval is granted) terminates for any reason, it is my responsibility to notify the International Programs Office, and to immediately purchase SHIP or another comparable insurance so that there is no break in coverage.
- I understand that upon receiving waiver approval I am solely responsible for all costs relating to the purchase of insurance and any medical expenses not covered by the policy I select.
- I understand that my health insurance coverage must be in effect on or before the first day of classes attended and must remain in effect until I graduate from the UI with *no breaks* in coverage at any time.
- I understand that I am responsible for renewing my insurance premiums annually (beginning of each Fall semester) and getting renewal information to the International Programs Office (IPO) Before the expiration date, so there is no break in insurance coverage at any time.
- I hereby give consent for my insurance agent to notify the University if the insurance I have purchased for my dependents and myself expires, and/or for the University to contact the insurance agent to verify the status of my insurance if questions arise about my coverage.

Dependent's Signature: _____ **Date:** _____

Student's Signature: _____ **Date:** _____

This is your signature page confirm that you understand all of the above and to allow a representative of the insurance company providing coverage to complete and return the second page

International *Dependent (spouse and/or children)* **Health Insurance Compliance Form**

This form is to be completed and certified (signed below) by the Insurance Company Representative Only and to be accompanied by page 1 (student signature page). Please type or print clearly and return both forms to the address below before student begins classes.

Insured's Name: _____
(Family or Last name) **(Given or First name)**

Insurance Company: _____ **Policy Number:** _____

Date Coverage Begins: _____ **Date Coverage Terminates:** _____
Month / Day / Year **Month / Day / Year**

The University of Idaho requires all exchange students (J-1) and dependents holding non-resident alien visas to be covered by insurance that meets US Department of State requirements. Please verify and check (✓) each requirement that applies to the insurance of the student listed above. He/she states that he/she purchased and maintains health insurance coverage that meets all requirements set by the University of Idaho for student dependents who hold non-resident alien visas (see page 1):

- □ Benefits of at least $50,000 per accident or illness
- □ A deductible not to exceed $500 per accident or illness
- □ Co-payment amount not greater than 25% (percent) so that the insurance pays at least 75%t of charges
- □ Accident and illness coverage (to include maternity insurance)
- □ Repatriation coverage (A type of life insurance whereby the deceased is returned to their home country)
- □ Medical evacuation coverage (If the student should be too ill to attend school, this pays for the student to return to their home country)

If additional dependents (spouses and children) are covered on this policy, please list each dependent below. Use separate page if needed to list all dependents.

A. Name: _____

Date of Birth: _____ **Relationship to Insured:** _____

B. Name: _____

Date of Birth: _____ **Relationship to Insured:** _____

I hereby certify that all information on this form is complete and accurate, and that health insurance for the student listed above meets all requirements set forth in items 1-10 above.

Print Name _____ **Position:** _____

Signature _____ **Date:** _____

Telephone Number: _____ **Email:** _____

U.S. Claims Office Address: _____

U.S. Claims Office Telephone Number: _____

Please return this form to:
International Programs Office, University of Idaho
Fax: (208) 885-2859 Email: ipo@uidaho.edu Phone: (208) 885-8984