

A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD MUST BE PROVIDED WITH THIS FORM TO BE ELIGIBLE TO WAIVE, IT MAY BE FAXED, MAILED OR HAND DELIVERED by September 1st (Fall) and January 26th (Spring)

First Name: _____ Middle: _____ Last Name: _____

CWID: A _____ Email Address: _____ International Student Y/N

Waivers will only be granted to those international students (F1 and J1) who have

- Health insurance coverage through a US-based employer

I have health insurance that satisfies the conditions listed below and do not wish to purchase the Student Health Insurance Plan.

- If your coverage does not meet all five of these criteria of comparable coverage, you may not waive, contact Student Health Services for more information. If you do not know whether your coverage meets these conditions, contact your health insurance plan administrator to get current, accurate information about your plan before completing this form.
- This waiver form must be completed and submitted before the waiver deadline of the term you wish to wave the student health plan.

Yes	No	My plan provides coverage for medically necessary care in the Chicago area equivalent to the coverage provided by IIT's student health plan. (Note- HMO's providing emergency coverage only do not meet this requirement)
Yes	No	My insurance plan provides maximum benefit coverage of at least \$100,000 U.S. dollars.
Yes	No	My coverage will remain in force as long as I am a full-time registered student at the Illinois Institute of Technology.
Yes	No	My deductible is \$2500 or less
Yes	No	My plan provides coverage for alcohol related injuries; it also provides mental health coverage in the Chicago land area.

I affirm that I have health insurance coverage that meets all five of the conditions described above. I am requesting to waive the IIT Student health plan. I certify that the information supplied is correct, and I am responsible for any incorrect information, whether international or otherwise. I understand I am legally responsible for any medical expenses incurred during my enrollment at the University, and that the University and its medical insurance program will not be responsible for any of my medical expenses. I understand that this information will be checked and verified at any time, and if my plan does not meet these requirements, or I am uninsured, I may automatically be charged for and enrolled in the Student Health Insurance Plan if I am a full time student or live in the Residence Halls.

I understand that this waiver will be valid for each term that I am continually enrolled in classes at IIT and that if I want to be enrolled in the Student Health Plan I will have to notify Student Health Services in writing. I also understand this waiver does not cause me to forfeit the right to utilize medical treatment at Student Health Services.

Signature _____

Date _____

Please check your student account within 3 business days to verify that the health insurance charge has been removed from it.

FOR OFFICE USE ONLY

Date received _____ Received by _____ Date Completed _____ Approved Y/N

Reason: NC NFC NBC IS CIA