# Academic Year 2024-2025 Waiver Form – *Fort Hays State University*

Kansas Board of Regents policy states "Each state university shall require any international student holding a F-1 visa and any exchange visitor holding a J-1 visa to show proof of health insurance coverage for each semester or term for which the student is enrolled, whether or not the student is participating in the Board's voluntary student health insurance program. Such proof of insurance shall be required prior to the student beginning classes."

All international students are *automatically* enrolled in the KBOR Student Health Insurance Plan. If you wish to waive out of this coverage, ***you must complete and return this waiver form along with proof of adequate health insurance coverage from another health plan that meets the university's requirements.*** **New waiver requests must be submitted EVERY fall or, if other coverage is for less than academic year, a new waiver request must be submitted for each semester or summer for which the student is enrolled.**

**Directions:** Complete Sections A & B of this form and bring or fax the completed form along with proof of your other health insurance (including your ID card) to the Student Health Insurance Coordinator **BEFORE** the applicable waiver deadline(s) listed in Section A. **Waivers received after the deadline will not be approved. Waiver Deadline:** ***August 19, 2024—Fall semester & January 1, 2025--Spring semester***

***Please Print***

**Section A**

I am requesting a waiver for the Student Health Insurance Plan for the following duration. ***(Please chose ONE of the following options)*** →

- ☐ **Fall Semester** ***8/19/2024-12/31/2024***
- ☐ **Spring/Summer Semester** ***1/1/2025-7/31/2025***
- ☐ **Summer Semester** ***6/1/2025-7/31/2025***

Student Information

| *Last Name/Family Name* | *First Name/Given Name* | *Middle Initial* | *University Student I.D. #* | |
|---|---|---|---|---|
| | | | | |
| *Hays Address* | *City* | *State* / *ZIP* | *Birth Date (Month/Day/Year)* | ☐ Female ☐ Male |
| | | | | |
| *Cell Phone Number* ( ) | *Email* | | | |
| | | | | |

**Section B**

☐ NO. **I do *not* wish to accept automatic enrollment in the Student Health Insurance Plan because I have health insurance coverage that meets ALL the University's requirements for waiver. I have read the description of student health insurance coverage provided. I understand that I am always legally responsible for all medical expenses I incur and that the University will not be responsible for any of my medical expenses.**

I have provided proof that my insurance provides the following required benefits and coverage:

A. Unlimited Maximum Benefit for covered medical expenses.
B. Coverage for essential benefits (with no dollar limits), as defined under the Patient Protection and Affordable Care Act. This includes pharmacy, mental health services, maternity benefits, preventive care, **and coverage for pre-existing conditions.** This also includes pediatric dental and vision coverage.
C. A policy year deductible of $500 or less.
D. Maximum total out-of- pocket expenses cannot exceed $8,200 per member ($16,400 per family) with preferred providers. Deductibles, coinsurance, and copays all count toward the out-of-pocket maximum.
E. A minimum of 75% coinsurance payable by the insurance plan to Network providers.
F. Plan is not Emergency/urgent care only.
G. At least $100,000 in coverage for repatriation and medical evacuation
H. My proof of coverage includes effective dates covering the entire period for which I am requesting a waiver (8/1/2024 through 12/31/2024 OR 1/1/2025 through 7/31/2025).
I. Plan document(s) in English, with currency amounts converted to U.S. dollars, and an insurance company contact phone # in the U.S.
J. Insurer has a base of operations in the US or has a US based claims payer
K. Insurer is authorized to do business in Kansas and is providing coverage under a policy that has been filed and approved by the Kansas Department of Insurance.

**Verifiable proof of coverage with student's name (ID card or certificate of coverage) required, with a copy of the insurance policy (or, a *summary of benefits*), or a letter from the carrier verifying all of these requirements are met.**

| *Name of Insurance Company:* | *Insurance Company Telephone Contact in US:* |
|---|---|
| | |
| *Name of Employer (if applicable)* N/A | *Insurance Policy #* |
| | |
| *Insured Name:* | *Relationship to Student:* |
| | |
| *Signature:* | *Date:* |
| | |

*For Office Use Only — Do Not Write Below Line*

| **Form Received By** | **Date** |
|---|---|
| **Coverage Verified to Meet Criteria in Section B:** | (Insurance Coordinator) |
| **Copy of ID Card/ Policy Received:** | (Insurance Coordinator) |
| **Waiver Accepted** | **Waiver Denied** |

Attention Students:

You must hand-deliver or scan and email this form, with your proof of other adequate health insurance coverage, to the Student Health Insurance Coordinator on your campus.

☐ **Hand deliver to campus-FHSU Memorial Union 014**
☐ **Email** – mkohl@fhsu.edu