

International Insurance Waiver Appeal Form

1. Term

___ Fall year _____ ___ Spring year _____ ___ Summer year _____

2. Student Information

Family (Last) Name First Name Middle Name

Date of Birth (MM/DD/YY) US Phone Number Email Address

3. Current Insurance Information

Name of Insurance Company US Phone Number Email Address

Address of Insurance Company

Insured's Name Date of Birth (MM/DD/YY) Insured's ID Number

Group Number Policy Number Effective Date (MM/DD/YY) Expiration Date (MM/DD/YY)

4. Reason for denial (found on notification email from AIG)

- ___ Coverage dates do not include the entire coverage period you are waiving.
- ___ Medical benefits are not at least \$50,000 USD for each accident or sickness.
- ___ Policy has an annual deductible of more than \$500.00 USD;
(a Health Care spending account is not acceptable as an alternative)
- ___ The minimum paid for covered benefits is greater than 75%.
- ___ Repatriation of Mortal Remains is less than \$7,500.00 USD.
- ___ Medical Evacuation is less than \$10,000 USD.
- ___ Policy excludes or unreasonably limits coverage for activities essential for students;
(such as a \$10,000 limit on motor vehicle accidents, a 13 week benefit period)
- ___ Other: _____

Student Name (please print)

Student Signature

Date (MM/DD/YY)

Committee Authorization: For International Insurance Waiver Committee Office Use Only:

Waiver Appeal: ___ Approved ___ Not Approved

Reason _____

Print Name Print Title Signature Date